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ON THE MEDICINAL USES OF ARSENIC.

One of the many excellent efforts in the direction of Collective Investigation undertaken by the British Medical Association was that made in the year 1846 as to the medicinal action of arsenic. Its results were summarized by Mr. Thomas Hunt, in the Transactions of the Association for 1849 (see page 383). This Report had, I believe, a not inconsiderable effect in removing prejudice (which was then strong) and in confirming the confidence which not a few in the profession were already beginning to entertain in this remarkable remedy.*

As the Report in question is probably not accessible to many of my readers, I shall venture to commence my present paper by a statement of some of its principal points.

All of those who reported concurred in the statement that they had never witnessed fatal results from the medicinal use of arsenic, and most said that they had never seen any serious detriment to health. A case is related (by Mr. Girdwood, page 404) in which by mistake a patient took during twenty-four hours two drachms of Fowler's Solution, and was cured by it of an ague without injury.

* One reporter actually forbids Dr. Hunt to mention his name. He writes: "I regard it as invaluable. I would sacrifice nine-tenths of the materia medica for arsenic. This, however, I state *privately*, for the prejudice against it is very strong, and I have neither time nor inclination to become its champion." Mr. Hunt speaks of the writer as one "whose experience in arsenic is, I believe, far greater than my own."

The Report affords a certain amount of evidence in favour of the belief that those who take much exercise in the open air may bear well double or treble the dose which would be suited for those of sedentary occupations.

It is generally agreed that a dose of eight to ten minims of Fowler's Solution three times a day is a full one, and ought but rarely to be exceeded. Much smaller ones had been employed by most of the observers.

It is noted that children usually take arsenic well, but I find no reference to the converse fact, with which I have myself been impressed, that with elderly persons the drug often disagrees.

There is a fairly general agreement that arsenic should not be given during the acutely inflammatory stage of skin diseases. There is, however, no reference to its specific powers over pemphigus, in which malady we now invariably prescribe it without any reference to stage.

There is a marked discrepancy in the observations as to whether arsenic should be regarded as a tonic or depressant. This Mr. Hunt endeavours to explain by suggesting that it is primarily a tonic and secondarily depresses. I may venture to suggest, however, that differences in dose have probably more to do with it.

As regards the special preparation used, there does not appear, from the replies given, any reason to believe that where the effects of arsenic are wanted, any better or safer salt can be used than Fowler's Solution. Here again we encounter the important question of dose. It does not follow that because you may give with impunity double the quantity of some other salt, that therefore the latter is really safer. What is required is effect, and the remedy which attains a certain end in three minim doses may be just as safe and useful as another of which you may give twelve with impunity. Dr. George Webster writes of De Valangin's Mineral Solvent (a hydrochlorate of arsenic) that you may give much larger doses, and that it is milder in its effects. Such statements need to be carefully tested before we accept them as of any real clinical importance.

There is no reference to the production of Herpes zoster

by arsenic, nor any to the now well-recognized result of a brown or earthy discoloration of the skin. Nor have we any suggestion that the drug may occasionally cause multiple neuritis, epilepsy, or paraplegia. Of the corneous condition of the palms and soles which occasionally passes into cancer we have no mention.

The occasional production of vesicles upon the soles of the feet (a symptom which some modern dermatologists appear to have forgotten) is, however, referred to in the following terms by Dr. Theophilus Thompson, and the observation is confirmed by Mr. Hunt:—"A gentleman to whom I had given Fowler's Solution for three months persevered with eight-minim doses after stiffness of the eyelids and nausea had occurred. Violent vomitings followed perspirations and copious discharge of urine which appeared to contain blood. In this instance some vesicles appeared on the feet (an appearance which I have somewhere seen mentioned as an occasional effect of arsenic)." Mr. Hunt adds: "The vesicles on the soles of the feet I have recently noticed in three different cases."

The conditions noted as indicative of disagreement are the following:—"Conjunctivitis," "swelling of the limbs and features," "irritation of mucous membranes," "purging," "gastritis," "desquamation of cuticle," "general inflammatory state," and "flushings." More specially connected with the nervous system are "headache," exhaustion, restless nights, sinking, giddiness, palpitation, and mental agitation and alarm.

The Report is, as a whole, very creditable to the zeal and fairness of Mr. Hunt, who was, as is well known, a warm advocate for the use of the drug. Mr. Hunt speaks with modesty of his own experience, and criticises the statements of others with much judgment. He urges with propriety the necessity of attention to his own well-known rules to begin with a full dose and reduce it on disagreement being manifest, to give it on a full stomach, not to use larger doses than from eight to ten drops of Fowler's Solution, and usually to be content with smaller ones.

Much of the Report deals with the use of arsenic against

ague, neuralgia, and allied maladies, and in this direction most confident opinions are expressed. One observer, Dr. William Dix, practising in a fen district, speaks of using "fifteen wine quarts of Fowler's Solution" in the year. Concerning this employment of the drug, we have fortunately of late years had much less experience, since malaria in its more severe form is almost unknown.

I will now take leave of this valuable Report and proceed to the record of some cases and observations of my own. Before doing so, I may mention that I published three years ago a Lecture on Arsenic, in which many of the points which I now purpose to discuss were referred to.

We shall probably place ourselves in the best position to understand the effects of arsenic, if we assume that, for the most part, it acts directly upon the cell elements with which it comes in contact. We may suitably avoid altogether hypotheses of reflex or "sympathetic" irritation and of influence on the blood-vessels. Being easily soluble, it is probably susceptible of almost infinite dilution, and being carried by the blood into contact with all the tissues, it probably affects their state by direct imbition.*

If we accept this as a basis of our inquiry, we have next to investigate as to which tissues show the greatest tendency to suffer. This is a question solely for clinical experience. It is a matter of all but universal experience, in reference to the lower forms of organic life, whether vegetable or animal, that arsenic tends to retard cell-growth and to destroy life. With the very rarest exceptions all cryptogamic forms submit at once to its influence.

We need not discuss the question as to whether arsenic should rank as a tonic or otherwise. It is extremely probable, *a priori*, that it would produce results apparently very different in different states. We might expect it on the hypothesis suggested to control processes of inflammation

* In reference to this hypothesis we need not place too high a value upon the negative fact that chemists have encountered great difficulty in detecting arsenic in the blood and soft tissues. The quantity present is probably exceedingly minute.

attended by cell-proliferation, since it represses cell-growth in general. In this way its influence over such a disease as psoriasis may be taken as explained. It is upon this power that the recommendation of its use in cases of cancer and new growth in general are based. Just, however, as it tends to repress excess of cell-growth when this exists as a disease, so by precisely the same action may it so degrade the vital activity of a healthy tissue as to cause it to take on disease.

Thus in some cases it may seem to clear the complexion, as in cases of acne, when it causes disappearance of pustules; whilst in others, if pushed, it may induce a muddy and dirty state of skin by lowering nutrition and favouring epidermic exfoliation.

I do not know of any examples of skin disease, produced by it, in which the changes assume the form of overgrowth. Such are common in the instance of iodiode of potassium, but (if we except the exceedingly rare occurrence of "arsenic-cancer") they are unknown in that of arsenic.

It is highly probable that it may cause neuritis, but we have not as yet any demonstration as to what special parts of the nervous system it can throw into inflammatory disturbance. We do not know whether, for instance, it influences the primary nerve-cells themselves, or the nerve-tubules, or the areolar elements by which they are surrounded. We know clinically, and beyond the slightest shadow of doubt, that it can produce that form of nerve-disturbance—probably a neuritis—which results in Herpes Zoster. And we know that it can cause numbness, loss of sensation, and muscular debility in varying degrees of severity. The Herpes which it causes is always non-symmetrical; but the motor and sensory forms of paralysis are only exceptionally so. These exceptions are, however, quite sufficiently numerous to give strong support to the belief that the action of the drug is direct and local. Some facts favour the belief that the terminal parts of the extremities are usually first affected, though by no means invariably so. It is exceedingly rare to meet with any form of paralysis affecting the trunk, the head, or the sphincters.

Dr. Graves cites Orfila as an authority for the fact that arsenic given to dogs causes paraplegia of the hinder extremities. These were cases in which arge doses were given. Periera does not mention paralysis amongst the results of arsenical poisoning.

Dr. Faulkner, in the *Memoirs of the London Medical Society*, vol. ii., has stated that he had repeatedly witnessed local paralysis as a consequence of arsenical poisoning. He alludes to one case in which the hands only were paralysed, and to two others in which the palsy spread gradually upwards from the fingers till the whole arms were affected.

In another case, published by Professor Bernt and quoted by Christison, after an overdose of the arseniate of potash, the patient lost sensation and the power of motion in the hands, and lost motion in the feet. In this instance there was contraction of the knee joints.

Dr. Murray, of Alford, has recorded in the *Edinburgh Medical Journal*, vol. xviii. p. 167, a case in which four persons were simultaneously poisoned by arsenic. In all the muscular debility was very great. One of them lost altogether the use of the muscles of the left arm, and six months later continued to be unable to bend the arm at the elbow joint. We may note here that the paralysis was unsymmetrical. In one of the other patients there was great general debility and long-continued numbness and pains in the legs.

It would appear that in most cases of arsenical paralysis, recovery, although long delayed, finally ensues. Dr. Christison, however, quotes from the *German Ephemerides* the case of a cook who had paralysis of all her limbs after acute arsenical poisoning, and in whom, although she lived for many years, the condition never disappeared.

A case is related by Dehan in which a woman who had taken by mistake a small quantity of arsenic began to suffer on the fourth day from cramps, tenderness, and weakness in all the extremities. The symptoms increased, until the whole extremities became almost completely paralysed. At the same time the epidermis desquamated. The power of motion returned first in the hands and then in the arms. She had a long illness, was in the hospital eleven months, but eventually recovered.

Case illustrating the influence of Arsenic in causing changes in the nutrition of the palms and soles, with tendency to epithelial cancer (Arsenic-Keratosis and Arsenic-Cancer).

I published some years ago some very important cases in which it was believed that the long-continued administration of arsenic in full doses had induced changes in the nutrition of the skin of the palms and soles.* These changes had ob-

* I am indebted to Dr. Colcott Fox for a reference to a statement by Sir Erasmus Wilson on this subject (Lectures on Dermat., 1873). It is to the effect that arsenic may produce not only desquamation of hands and soles of feet, but also thickening of epidermis to a considerable degree from hyper-nutrition, and may occasion the formation of minute granular corns, each little corn corresponding with the aperture of a sudoriferous duct.

served several stages. First, a peculiar dryness and burning of the part; then the production of little corneous indurations; and finally, in three instances, the development of epithelial cancer of a peculiar type. To the latter I ventured to give the name of Arsenic-Cancer. Since these observations were made I have had many opportunities for, in part, confirming them, and they have also been confirmed, in part, by many other surgeons. Thus it is, I think, now generally admitted that arsenic may cause the skin of the palms to crack and become dry, and that it may develope little corn-like epidermic indurations. I am not aware, however, that any new observations have been recorded bearing upon the statement that as a final stage these corns may end in epithelial cancer. Nor have I had myself, during the six years which have passed, any case which I could claim as an example of "arsenic-cancer." Within the last few weeks, however, I have been consulted by a gentleman whose case most remarkably supports the views to which I refer. He is now a man of 40, and in good general health. Five years ago, being the subject of an abdominal tumour, which was believed to be a sarcoma and was rapidly growing, he was advised to take arsenic. As the drug appeared to him to diminish the growth of the tumour, and to greatly benefit his health, he did not keep to the dose which had been prescribed. He often took from half a drachm to a drachm a day of Fowler's Solution, and he continued this for two years at least. The only inconvenience which the drug produced was occasional purgation, and as this appeared to relieve his abdominal symptoms, and in particular to reduce the ascites from which he suffered, he persevered in the use of the large doses, without obtaining further medical advice. At length he began to be annoyed by great sweating of the palms and soles, and next the epidermis began to thicken in patches, and to form corns. The arsenic was continued in reduced doses for a year longer, when, the state of his hands and feet becoming more and more troublesome, and appearing to be distinctly attributable to it, it was almost wholly laid aside. When I saw him it was four years from the commencement of the arsenic, and a year after its almost total disuse. The changes in the nutrition of the palms and soles had gone on

slightly increasing rather than otherwise, during the year in which the arsenic had been disused. The palms of the hands and the palmar aspects and sides of the fingers were covered with hard corns, from the centres of many of which the epidermis was breaking up in flakes. In some places, by the confluence of these corns, ridges had been produced. On the soles of the feet there were similar conditions, which advanced, especially in the region of the heels, up their sides. In more than one position there was a tendency to papillary growth, which could not but cause anxiety as to its being an early stage of cancer.

Life-long use of Arsenic—Epilepsy—Arsenical Eczema (Herpes)—Temporary Diabetes and Albumenuria.

In the case which I have next to relate we have an illustration of the almost life-long use of arsenic. It is many years since the patient was under my observation; he has, indeed, now been dead for at least ten. Sir George J. was a gentleman of high eminence in the legal profession. He was about 60 when I knew him, and had taken arsenic almost from boyhood, with interruptions, but never leaving it off for a whole year. His complaint was a peculiar form of psoriasis. Arsenic had often cured this skin disease, and had always shown a remarkable degree of power over it. No other drugs had, I was assured, ever done it the least good. Sir George had been under the care of most of the London dermatologists of his day, and under several Continental ones, he had also formerly been a patient of Sir Benjamin Brodie, Dr. Copland, Dr. Prout, and others. Possessing a highly-trained mind, he gave me his evidence in a most lucid manner. When he consulted me he was apparently in vigorous health in all respects, but his psoriasis still troubled him. This eruption had begun, he said, at the age of 17, and Sir Benjamin Brodie then placed him under the treatment of the late Dr. Gaskoin, who administered arsenic in full doses. As the result, as he believed, of the drug, an epileptic seizure occurred.* This fit was

* A case in which epilepsy occurred in connection with arsenical poisoning is recorded by Dr. Rougart. "A girl swallowed a drachm of white arsenic, and soon experienced the usual symptoms of violent intestinal irritation. At the end of

never repeated, but it was because he had several times since, when taking full doses, experienced sensations in his head which led him to think that he was going to have another fit, that he was convinced that the first, and only one, was caused by it. Some time later, and again when under the influence of arsenic, he had a fainting attack. Many years after this he suffered much from pain in the top of the head —"a creeping" and sometimes "a twisting feeling" in the middle of the top of the head. He consulted several physicians for this, and some suspected that he had organic disease. It finally, after some months, disappeared when he left off the arsenic.

On several occasions, as a definite result of arsenic, he had suffered from extreme irritability of bladder, so that he was obliged to pass water every half hour, and could not retain it for a minute after the desire had commenced. He believed that on these occasions the kidneys were stimulated as well, and that the quantity was much increased. This symptom always disappeared when he left off the drug. I have seen several other cases in which exactly the same symptom was experienced. In one of them it was attended by great reduction of the virile function, but this never happened in any degree whatever in our present case. Sir George was quite familiar with what he called "Arsenical eczema," but did not appear to have ever had herpes zoster. Of the eczema he had had many attacks, and he gave me the following facts respecting it. It will be seen that it had differed very much from true eczema. The eruption usually occurred in large patches on the thigh, arm, or trunk, oftenest on the thigh. These patches, sometimes as large as the two outspread hands, usually first appeared as groups of small red spots, which rapidly became vesicular, and then soon dried up. The eruption never lasted

twenty-four hours these had somewhat subsided, but after another day she began to complain of coldness in the spine, giddiness, intolerance of light, and fainting. She had also aching of the extremities and tingling of the whole skin. At the end of the sixth day she had an attack of left-side convulsions, with foaming at the mouth, with total insensibility; the attack lasted two hours, the insensibility remaining through the night. A succession of similar but slighter attacks occurred during the next fortnight. But eventually she was restored to health." —*Medical Chirurgical Transactions*, vol. ii. p. 134.

more than three or four days, and within a week it was usually quite well. He did not remember that the patches had ever occurred symmetrically, and as a rule only one had been present at once. In these features of spontaneous curability and of non-symmetry we may note that it conformed much more closely to the character of herpes than that of eczema.

Of the more ordinary symptoms of arsenical disagreement, —red eyes, irritable stomach, palpitation or debility,—Sir George had never had the least. Sometimes he had experienced some abdominal pain, attended by slight tendency to diarrhœa, but never amounting to colic.

A very curious, and to me wholly new result of arsenic-taking had been noticed on two occasions, namely the production of temporary diabetes. On one occasion Dr. (now Sir) George Johnson found sugar present in considerable quantity, and on another, although no analysis was made, the evidence is conclusive, for the urine doubled in quantity and in specific gravity at the same time. On both occasions the diabetes was only temporary, and ceased soon after the arsenic was stopped. On another occasion the urine for a short time contained much albumen. Many times the quantity of urine had been greatly increased, and it is quite possible that in some of these also sugar may have been present. No numbness of the feet or hands had ever occurred.

Sir George had often tried to do without arsenic, but had never found that he could keep down his skin disease by any other treatment. He had often taken four months' courses, and he believed that he had usually had full doses. The exact doses which he had used he did not know.

Although such varied and definite maladies had at different times been produced by the arsenic, yet we cannot allege that on the whole it had interfered with the health. On the contrary, he had maintained, partly perhaps by its aid, a condition of unusual vigour in all respects. He was married, and the father of several children. He was moderately stout, and rather florid.

If we hold the proof deficient that the arsenic caused either the epileptic attack or the fainting fit or the long-continued pain in the head, for all these may possibly have been due to

other causes, we still have in the other symptoms a series of important phenomena, respecting the cause of which no doubt can be felt. I have therefore thought the case worthy of being recorded in detail. It is one to which I have on several former occasions briefly alluded.

Case showing the influence of Arsenic upon the Nutrition of the Extremities—Psoriasis leaving Stains—Very definite cure of the Eruption by the Drug.

A chemist's assistant applied to me for advice as to his skin. As he appeared to be a very intelligent man I took the opportunity of recording his experience as to treatment. He told me that he had had psoriasis from boyhood, and that one of his sisters suffered also. It had not given him much trouble until of late years. He had taken arsenic several times, and twice in what he called "regular courses in large doses," that is, gradually increasing doses up to ten minims three times a day. When pushed in this manner it always acted, he said, very definitely. On one occasion it had made the skin of his hands peel, so as to almost disable him from his occupation. This occurred quite early in the course, and did not persist very long. The backs of the hands were more affected than the front. He remembered that at the time of the peeling his hands used to tingle and burn.

At the time that he came to me he was absolutely well of his psoriasis. He came because some stains had been left where the patches had been. He was anxious about these because he fancied they implied some syphilitic taint. For this suspicion there was no foundation whatever, for he had never had syphilis. His skin was supple and soft and quite free from scales, but in all parts where the patches of psoriasis had been it showed a deep brown tint, which marked their areas quite abruptly. The patches were in their usual positions on arms, back, and limbs, and many of them as large as an outspread hand. He was a man of very dark complexion, black hair, and very swarthy skin. I assured him that the pigmentation of the patches was due chiefly to his complexion, and to the large quantity of movable pigment in his system, and not to syphilis or any peculiarity in his eruption. At the same

time it was quite possible that the general pigmentation of skin was partly due to the arsenic.

As he was well experienced in drugs I asked him if he had not tried the effect of chrysophanic acid. He said that he always used it for the scalp and face, but never for his body on account of the inconvenience. The large doses of arsenic had, he said, never disagreed with him, and he had established his cure by continuing them some time after the eruption had disappeared. He had only left them off about two months when I saw him, and was then in excellent health.

(*To be concluded.*)

NOTES ON THE USE OF MERCURY.

On many subjects, and especially those in which therapeutics are concerned, we may recur with interest and profit to the detailed writings of our predecessors. They used most of their drugs with a freer hand than we do, although respecting a few they were more timid. In the all-important art of prescribing there is much to be learnt from them, if we read their precepts and, above all, their case-records, with due judgment. In the preceding article I have thought it worth while to reproduce the chief points in a Report on Arsenic, which is now nearly half a century old. I now venture to offer to my readers some fragmentary notes on the uses of another of our great remedies, in part selected from the writings of our forefathers, with which I shall intersperse my own comments.

The Opinions of Sir Astley Cooper.

The following very practical observations on Mercury are from the pen of Sir Astley Cooper, and were published soon after his death as Selections from his Note Books:—

"*Effects of Mercury.*—Brassy or smoky taste in the mouth—the gums white and swollen—the teeth unusually sensible to cold air and water—gums ulcerated about the roots of the teeth—the cheeks ulcerated opposite the dentes sapientiæ—the teeth loose and often painful—increased quantity of saliva secreted—bleedings from the gums and cheeks—sloughs from the gums and cheeks, and exfoliations of the lower jaw.

"Chilliness—sensation of cold water running down the back—pulse quickened—increased secretion of urine—loss of appetite—restlessness—sweating—purging—tenesmus, vomiting, irritation in the skin—pains in the joints.

"If an effect is produced by mercury, and from any cause

the use of the mercury is suspended, it becomes extremely difficult again to occasion a mercurial effect.

"*Increasing its Effect.*—The warm-bath is the most certain mode of making the mercury affect the mouth. Mr. S—— had used mercury so as to affect his mouth for a node on the tibia; great inflammation came on in the bone, and it was necessary to suspend the use of mercury. When he had recourse to it again, the mouth could not be affected, although half an ounce of mercury was used in the form of ointment. I ordered a warm-bath, and in two days the mouth became sore. Mr. R—— had great difficulty in affecting himself with mercury; he used the warm-bath, and in three days the mouth became very sore.

"*Decreasing its Effects.*—The effects of mercury are decreased by bark, wine, and stimulating food of all kinds—by opium more especially—also frequently by purges—in the mouth by a gargle of argent. nitrat."

It will be seen that in the preceding notes Sir Astley mentions some symptoms which in the present day we never see, such as hæmorrhages, sloughs of the cheek, and exfoliation of jaw. We now give small doses, and carefully stop short of producing symptoms such as those. His observation as to the protective power of tonics, wine, &c., is one which I can well confirm, and upon which, indeed, I have often insisted. I never prescribe quinine with mercury unless under special conditions, believing that it simply implies the necessity for double doses of the latter in order to produce a given effect. His observation as to the influence of warm baths in favouring the development of ptyalism was new to me when I read it, but it is quite in keeping with what I have long known as to the efficiency, in this direction, of warm rooms and, above all, of confinement to bed. Of late I have often advised syphilitic patients under mercurial treatment to take a bath every other night, and I think with the result of assisting the cure. It is quite possible that in prescribing opium with mercury in order to prevent bowel irritation, as is now almost constantly done, we ought to remember that to some extent the opium is protective. The observation that patients become accustomed to mercury, and that after one

salivation it is not easy to produce a second, is important and probably well founded.

I will now turn to the experience of another master in our art.

The Opinions of Sir Benjamin Brodie.

From a lecture by Sir Benjamin Brodie on the effects of mercury I extract the following :—"Upon first taking mercury, the patient frequently appears to improve in health and spirits, but if the medicine be continued for too long a period the very opposite effects to these are produced." The contrary to this has often been my experience, but everything probably depends upon dose. Brodie thought five to ten grains of mercury, with chalk, twice or thrice a day, efficient only for a slight mercurial action, and two grains of calomel, twice a day, hardly enough. I should not give more than a quarter of such doses.

Brodie believed that mercury could produce symptoms resembling those of syphilis, and he particularly mentions ulcerations of the mouth and throat, rheumatism, inflammation of the iris and nodes. He adds, "In some cases of these mercurial nodes you will yet find that mercury cures them." I cannot but think that he was too credulous in believing that mercury caused nodes, and so also as regards iritis. I have never seen any facts supporting such a creed.

Brodie insists that the patient's health should be well sustained whilst taking mercury. He also remarks that cold is an antidote to mercury producing its proper effects, and that if the patient be not easily affected he ought to be kept to a warm room. He was a firm believer in sarsaparilla as a substitute for mercury, giving a drachm of the extract in a pint of the compound decoction daily. He gives the following interesting description of a class of symptoms which we now seldom or never see :—

"Mercury sometimes acts upon the nervous system like a mineral poison, and symptoms similar to those which it produces in these cases may arise from arsenic, tartarised antimony, and iodine; these consist of weakness, and debility, constriction of the chest; small, feeble, and irregular

pulse; frequent sighing, and incapability of making any bodily or mental exertion. Mr. Pearson used to call this disease the mercurial erythysmus: sometimes there is vomiting and sickness, with convulsive trembling of the limbs; this affection generally arises from the mercury being improperly persevered in, and if it is left off, the symptoms will be in some measure arrested; but time alone will cure the disease, and thus allow the mercury to be eliminated from the system. Sometimes the tongue is covered with a thick, black, crusted fur, as in typhus fever; and if the patient is low and depressed, he will require ammonia, wine, and other stimuli.

I will next adduce a case which affords an illustration of the methods of treatment in vogue in the earlier part of Brodie's career. It was not under his care.

The Treatment of Syphilitic Iritis half a century ago—Use of Mercury, Bleeding, &c.

A woman, aged 41, went through a severe attack of syphilis in January. She had eruption, sore throat, and slight iritis. She recovered after a short course of specifics. In the following August, whilst in a state of debility and cachexia, one of her eyes was attacked by severe iritis. Her surgeon ordered mercury, opium, and antimony, and four days later she had mercurial fetor. The eye was worse, in spite of the mercury, and turpentine was substituted in one-drachm doses. After temporary improvement, the eye, five days later, had relapsed, and the pain was intolerable. Although the woman appeared very weak, she was now bled to twenty ounces, and bore it well. Three days after this, however, the eye was still worse, and the turpentine being considered to have failed, it was laid aside, and mercury again given. Two grains of calomel, with a quarter grain of opium, were ordered three times a day. Under this, in two days, the gums were again touched. Definite improvement did not, however, result until ten days later. It is then recorded, "The mercury has acted most powerfully, producing ulceration and swelling of the cheeks; the inflammation has diminished, and the pain is gone."

The patient was now very weak. She had been bled from the arm three times. The iritis lingered for a month longer, and finally disappeared under small doses of bichloride. On November 16th the surgeon in charge of the patient writes, "She was discharged quite well, and, I believe, free from venereal taint." Comments are added as to the great value of bleeding in syphilitic iritis, and the unwisdom of trusting to mercury.

I have abstracted the above case from a detailed narrative published fifty years ago.* Some questions of much practical interest occur in respect to it. In the first place, we may note that the iritis was a second attack, and occurred six months after the recovery from the first and from the other secondary symptoms. Next, it was a very severe attack. Turpentine failed to do any good, although given in larger doses than we now usually prescribe it. The iritis persisted in spite of mercury. This we not unfrequently see; indeed, in some cases, iritis will begin in one eye whilst the patient is salivated for the cure of the other. Yet in the end it appeared to be mercury which conquered the disease. Although the abstraction of blood always gave temporary relief to pain, &c., it is impossible to join the narrator in the belief that it did any definite good. Respecting a very large majority of cases of syphilitic iritis, it is, I think, true that they yield very quickly to mercury. In some cases iodide of potassium is sufficient, and in a few atropine drops may suffice. There are, however, a few cases like the above which resist everything, and these require the utmost judgment for their management. It is the same respecting a few cases of syphilitic disease of the skin and of the throat. The modern surgeon has in atropine drops, as contrasted with the extract of belladonna of our forefathers, a remedy of much increased power. Apart from its invaluable effect in keeping the pupil open, it probably exercises a beneficial influence over the inflammatory process. If we attempt to contrast the treatment which this patient received with what she would

* I do not mention the source from which I take this narrative, because I am obliged to criticise the treatment. It is reported in great detail and with much ability in a medical periodical.

probably have had in the present day, we may note that it was in a general way too heroic. The doses of all the remedies were too large, and the bleedings too liberal. Had mercury been given in smaller doses, and ptyalism avoided, it is probable that it would have been found more efficient. Had it been combined with iodide of potassium, it might have helped. Possibly if, instead of bleeding, quinine had been given with the mercury, it might have been well. In venturing these strictures, however, it is impossible not to admire the directness and courage with which the surgeon pursued his aims.

The case further illustrates several points in the natural history of syphilis. The attack of iritis which proved so troublesome was the result of a recrudescence of the disease, for the patient had been cured by a short course of specifics of a complete and rather severe outbreak of secondaries six months before. It is precisely these relapses which not unfrequently prove rebellious under treatment. I have recorded above (see p. 111), with an expression of doubt, Brodie's opinion that mercury may sometimes cause iritis. Although I have seen nothing which could lead me to believe that such is the fact, I must acknowledge that I have seen many in which it did not prevent, and not a few in which, as in the above, it apparently failed, for a time, to exert any power.

Mercury as a possible cause of Jaundice—Jaundice during treatment for Syphilis.

It was the opinion of some of the older writers that the administration of mercury occasionally caused jaundice. The cases which were cited in illustration were, however, always instances of the use of mercury in syphilis, and there remained the fallacy as to whether the disease and not the drug was the cause of the liver disturbance.

I have myself seen but few cases of jaundice occurring in the course of syphilis, and have not been able to form any very definite opinion as to its relations to that disease. A few cases by various observers are, however, on record. One such, which ended fatally, I will quote.

A young woman, aged 26, had been treated during nine months by interrupted courses of mercury for "pseudo-syphilis." She had been at least twice smartly salivated, although no secondary symptoms had ever shown themselves. She became emaciated, weak and rheumatic. Whilst fully under the influence of mercury by inunction, jaundice set in, and in three days she suddenly became maniacal, upon which coma followed, and she died in two days. Excepting general bile-staining the autopsy revealed only negative conditions.* It is not in the least conclusive that either the mercury or the syphilis had anything to do with the jaundice, though it is certainly true that the latter developed during ptyalism. The patient had been taking arsenic for a long time. The cerebral symptoms, although possibly due to the latter, were more probably the result of bile-poisoning.

On the Doses which should be given when it is not intended to salivate.

In looking back on the practice of the preceding generation of surgeons in respect to mercury, our attention is chiefly attracted to the largeness of the doses which they prescribed. We must remember that they had a distinctly different aim to that which we pursue. They designed to produce ptyalism, and to do it quickly and sharply. We in most instances desire to avoid this result, and to allow the mercury to act quietly upon the blood and tissues without any obvious manifestations of its presence. Thus we may easily fall into the error of giving too little.

The solution of the bichloride of mercury is a most efficient remedy and very convenient in use, but, unfortunately, some have got into the habit of ordering doses which are much too small. I have seen fifteen drops ordered for an adult. A lady, who brought me a syphilitic infant, said that she had taken medicine all through her pregnancy for the benefit of the expected child. I found that she had taken only half-drachm doses, and they had, of course, proved inadequate.

* I have unfortunately mislaid the reference to this case, and cannot now ascertain it. The abstract is made from a detailed report in an old medical journal.

A patient wrote to me, "I have no reason to complain of the treatment as, notwithstanding the disease and the quantity of mercury I have taken since May last, I never enjoyed better health in my life than I have done this winter, although I have had a great deal of hard work and exposure to all weathers, day and night." I looked up my notes of his case, and found that this patient had taken two-drachm doses of the solution of perchloride three times a day for ten months.

It is very difficult to formulate any rules as to doses in what we may call the quiet treatment of syphilis, when the aim is to procure the disappearance of the phenomena, but not to disturb the health. That we may often keep the disease absolutely in check whilst we are yet giving the remedy inefficiently seems very probable. My impression is that we ought, under such circumstances, always to give as much as the patient will bear without inconvenience, and that we ought not to content ourselves with the disappearance of symptoms. My own favourite preparation is grey powder, and in doses usually of a single grain. I much prefer to increase the frequency of the dose rather than to augment its strength. Not unfrequently this dose is well borne every four, three, or even two hours, the patient being instructed to take it regularly night and day. Even when a pill has to be taken six or eight times a day, the inconvenience to the patient is far less than that of the inunction plan or the mercurial vapour bath. If the importance of regularity be explained patients easily acquire the habit. In making these suggestions I am by no means thinking of syphilis only, for in the treatment of many other forms of chronic disease long courses of small doses are invaluable, and do not in the slightest degree risk injury to the health.

Syphilis in its early stages suppressed but not eradicated by long courses of Mercury.

A very definite illustration of the fact that a course of mercury commenced in the earliest stage of syphilis may prevent its development only so long as it is continued has occurred to me recently. I have seen many. In the present instance a man of thirty-six came to me first, in the sixth week after con-

tagion, with a well-indurated chancre. I prescribed my usual pill, a grain of grey powder every four hours. He began this on May 3rd and continued it till November, and during the whole of that period he had no secondary manifestations. His sore, which had quickly disappeared, never recurred. In November he contracted a gonorrhœa, and for it consulted another surgeon, who advised him to leave off his mercury. This he did. Two months later he came out in a general and well characterised papular eruption. He consulted me again for this rash a month or six weeks later still. It was then, in spite of some specific treatment, very well marked, and it was attended also by patches on the lips and tongue. The tongue was in a condition of syphilitic psoriasis. Thus it is clear that the six months' mercurial course had been sufficient to hold the disease very completely in check, but yet had not cured it.

It is as yet an undetermined question as to how long an "abortive" * course of mercury should be continued. I find myself, however, as years go on, inclined to insist on longer and longer periods.

The case which I have adduced is of value not only as illustrating suppression without actual cure, but as a proof of the possibility of suppression. We see that the chancre vanished and that not a single symptom of constitutional infection occurred so long as the mercury was continued. It is one of those in which the prevention of symptoms was so complete that doubts might have been felt as to the nature of the chancre. By some it is, I know, customary to doubt the diagnosis of syphilis if no secondary symptoms have occurred. Yet we find that the proof was soon afforded when the specific was laid aside. Had the latter been continued it is very probable that the patient would never have shown any symptoms. Yet he would undoubtedly have gone through syphilis. Let me repeat that in these respects the case is no exception to rule, but illustrates what is usual. Under an "abortive" course of small doses, carefully watched, it is the

* The term "abortive," as here used, means not inefficient but suppressive,—designed to procure abortion of the syphilitic disease—to arrest its development *ab initio*.

almost invariable rule for syphilis to end with the chancre. If, however, the course be prematurely stopped it is equally the rule for some manifestations to occur. The severity of these will probably depend upon the length of previous treatment. My experience is that the rash is under such circumstances usually a very mild one, and that it is not often attended by throat symptoms.

NOTES FROM CONGRESSES AND CONTINENTAL HOSPITALS.

Two years ago, on returning from the Birmingham meeting of the British Medical Association and Berlin International Congress, I offered to my readers some fragmentary notes respecting topics of interest which had been brought under my observation on those occasions. During the summer of 1891 I made no journeys, but during that which is just closing I have seen much. In July I was in Dublin to attend the Tercentenary of Trinity College, soon afterwards in Nottingham at the Medical Association meeting, and I have now just returned from a month's continental tour which has comprised several cities, but of which the principal object was the Second International Congress of Dermatology, held under the presidency of Professor Kaposi, in Vienna. If I now venture to record a few reminiscences of these occasions, it must be with the clear understanding that I make no attempt to do justice to them, or to those who took part in them. As throughout my ARCHIVES my selection of subjects for notice is guided solely by my individual interests, I shall now consistently restrict myself to topics which brought new knowledge or new suggestions to my own mind.

The occasion at Dublin was one of historical and social rather than of professional interest. There were, of course, no medical meetings, and there was much to distract the attention from such pursuits and to seductively occupy the time. I made, however, a few hospital visits, and was some hours in the museums of the Royal College of Surgeons and in that of Trinity College. In the latter I had the advantage of the guidance of the present Professor of Surgery in the University, Dr. Bennett, one to whom the Museum owes

very much. In the College of Surgeons Museum every possible facility was afforded me for the inspection of the specimens which interested me. I was also favoured with an opportunity for the quiet examination of a large collection of drawings, &c., collected at different times, and not usually accessible. Amongst these I found some of great interest and value. As is, however, not unfrequently the case with drawings, their value was in many cases impaired by the absence of history of the patient.*

Tracheotomy Treatment of Diphtheria in Dublin.

With Dr. W. Thomson I had some conversation on the subject of tracheotomy and other measures in the treatment of croup and diphtheria. Dr. Thomson is one of the few advocates for operative measures amongst the present race of Dublin surgeons. From a senior and leading operator I received an expression of most unqualified disapprobation of them. My inquiries resulted in a strong impression on two points: first, that the opportunities for experience have as yet been comparatively limited, there not having occurred in Dublin that prevalence of diphtheria which has recently been encountered in London and many continental cities; and secondly, that tracheotomy in diphtheria, unless performed by men of special experience in respect to it, is a procedure almost invariably resulting in death. On this latter point the facts which have accrued in Dublin do not differ in the least from those of Paris, London, and other places (see ARCHIVES, Vol. IV. p. 15, *et seq.*)

Encrusting Periostitis.

On stair-landing of the University Museum there stands the skeleton of a lion, which affords a most beautiful specimen of encrusting periostitis. Almost all the long bones are affected. This skeleton may pair well with that of Landseer's dog in the University Museum of Edinburgh, which a late professor used to cite as an instance of mercurial influence, the animal being supposed to have licked its master's paints,

* Of these I was with great liberality permitted to bring away about a dozen in order to have them copied in London for our College of Surgeons collection.

and these being supposed to have contained mercury. The skeleton of a lion which had never had access to a painter's studio, and yet shows exactly the same malady, may be held to give a final quietus to this far-fetched hypothesis, and if need were to disparage yet further the notion that mercury can cause periostitis. The real nature of this encrusting periostitis—which is, for the most part, a disease of the lower animals, and of those kept in domestication—remains an unsolved problem (see ARCHIVES, Vol. II. p. 197).

Exostoses in Birds.

In the Museum of the College of Surgeons there are some specimens (for me new) of the formation of huge ivory exostoses on the bones of turkeys. Twenty years ago I described from the Brighton Museum, where it was shown to me by Dr. Ormerod, the thigh bone of a turkey surrounded by growth of ivory hardness.* The specimens in Dublin are, however, yet more curious, and there are several of them. In one the whole of the space on each side of the keel of the sternum, normally occupied by the pectoral muscles, from which the carver cuts his slices, is symmetrically taken up by ivory-like growths. These rise to a level with the keel. I was told that the bird, a very fine one, was actually "served at a nobleman's table," and that its pathological condition caused great disappointment. Several other adjacent bones are affected in like manner, and must have greatly increased the weight of the bird. These, although related to encrusting periostitis, differ in some features widely from it. It would appear that the turkey is the bird chiefly, if not exclusively, liable to these formations, and further, that they are quite compatible with good health.†

The Annual Museum of the British Medical Association.

I may confess that my chief attraction to the meetings of the British Medical Association is its annual Exhibition or

* See woodcut illustration in the *British Medical Journal* under the head of "Museum Notes."

† I have many other notes from the Dublin Museums, but will defer them for the present.

Museum. In it I always find drawings, preparations, or models which interest and instruct, whilst they do not bore me. To the Section Rooms and the Addresses I am drawn by a much weaker force. As a rule, though not invariably, I can read an address or paper with less weariness and more profit than I can listen to one. In the museum, however, there are objects which no printed description could have enabled me to realise fully, and which can be appreciated almost at a glance. It is to be wished that the annual displays collected by our Association had more of the Museum and less of the Exhibition in their character. This may, however, be only an individual opinion, and there may be many to whom the displays of drugs, foods, instruments, and health appliances are more valuable than clinical and pathological illustrations. As regards the latter, I have also to make the complaint that they are but too often left in a comparatively uninstructive state by the omission of adequate descriptions and case-histories. If the numerous clinical observers now amongst us who make it a duty, whenever it seems desirable, to procure permanent illustrations of their cases by photography or drawing would keep this Annual Museum in mind through the year, and send what they collect with full descriptions appended, the value of these collections would be greatly increased. They would indeed soon become, in these rapidly-advancing times, unrivalled opportunities for the easy acquisition of the newest clinical knowledge.

The Annual Museum at Nottingham was a good one, and contained much that I was glad to see. A series of preparations and models illustrating diseases of the brain, sent from the Wakefield Asylum, was particularly worthy of attention, and so also was a series of drawings, relating to various subjects, contributed by the surgeons of the Leeds Infirmary. Any one wishing to realise exactly what is meant by the term "Erythema indurée des Scrofuleux" (Bazin) had an excellent opportunity offered by some beautiful drawings shown (with many others) by Dr. Colcott Fox. So also of *Adenoma Sebaceum*, of which Dr. Radcliffe Crocker had some beautiful models. If I may venture to offer a hint to those

who have the management of these collections in the future, it is, that more space, and better kind of space, should be reserved for this, the properly professional and scientific, part of the annual display. The best and most accessible room should be always kept back from the clamorous and cash-backed demands of druggists and instrument makers, and reserved for clinical pathology. Although the early demands for space may be small at first, the whole of it is sure to be taken up in the end. Exhibitors of objects of this class are seldom business-like in the direction of sending their exhibits beforehand, and often prefer to be their own caretakers of their treasures in transit. Tradesmen, on the contrary, apply well beforehand, and but too often secure all the best space. I speak as one who on more than one occasion has had charge of the details of these temporary exhibitions when I advise that space should always be reserved for late comers, who very often bring the best things.

The Congress Museum (Vienna).

In connection with the Vienna Dermatological Congress there was an exhibition on the same plan as that which since the year 1868 has constituted an important feature in our British Medical Association meetings. It was arranged in a large room close to that in which the Congress met, both being part of the magnificent buildings in which the Imperial University has its home. Nothing could possibly exceed the convenience of the arrangements. Before and after the sittings the Museum was always full of visitors, and ample opportunity was afforded to all, not only to inspect its contents, but to examine them critically, and in company with others whose knowledge made conference valuable. Never was a better opportunity afforded for the informal interchange of opinion amongst those engaged in the same pursuits. My only regret was that this collection, large as it was, was not still larger, and that it did not display all the wealth of dermatological drawings, &c., which Vienna could produce. I was afterwards favoured to a private and necessarily hurried inspection of Professor Neumann's port-

folios, and felt regret that I and others had not been able in the Museum to go through them at more leisure. It is a pity that any pictorial illustration of interest should be hidden away in a private cabinet, for we none of us know the degree of interest which those which we thus seclude may have for others.

As an illustration of the great value of these exhibitions, I may mention that I had myself taken to Vienna a paper, illustrated by drawings, dealing with the subject (to me new) of superficial melanotic staining of the cheeks, accompanied by the formation of unpigmented epithelial cancer in close proximity. Of this I have now had five or six cases, and the pathological fact is one of great interest and suggestiveness. In the Congress Museum, on a screen appropriated to contributions from Professor Billroth's collection, I found a portrait which illustrated precisely the combination in which I was interested. It showed a face upon which was a large, quite superficial and non-ulcerated, black stain, and near to this stain, on the left lower eyelid, there was an ulcer in all respects resembling rodent cancer. This latter showed no pigment. There were other conditions of much interest in the portrait, which possibly brought the case into near parallelism with that which Mr. Willett permitted me to give in my last number from his wards in St. Bartholomew's. I must not, however, venture to say more on this point, as I have not yet got the history (which I am promised) of the Vienna case. In a collection of photographs sent to the Museum from Paris, I found yet another portrait illustrating this superficial melanotic staining, but in it there was no co-existing epithelial cancer. It is not by any means improbable that other observers may possess other portraits carefully preserved in their private portfolios which bear upon the same subject, and by the aid of which it might be much elucidated. I mention this particular subject only as an example of the advantages which might ensue if those who possess drawings would be kind enough to bring them all into public display at some of our temporary exhibitions. The Congress Museum had also its negative side. I noted that no single portrait was exhibited either from Vienna, Paris,

or elsewhere, illustrating the very peculiar and striking form of lymph angeioma, which I have called lupus lymphaticus. Nor does any Continental atlas contain a portrait.* Those given by Mr. Malcolm Morris in the International Atlas were all from English sources. I have myself seen at least eight examples of this malady, and it is now more than twelve years since it has been described and figured. May we assume from this absence of illustrations that it is really much more common in England than elsewhere? The absence of portraits bearing upon adenoma sebaceum,† pityriasis rosea, and dermatitis herpetiformis was also to be noted. I mention these not in the least as pointing out deficiencies, but rather as suggesting that their absence may have some negative value as evidence. The collection was enriched not only by contributions from dermatologists, but by a large series from Professor Billroth, another from Professor Albert, and a most valuable series of specimens from the Pathological Institute. These latter Dr. Paltauf was good enough to demonstrate to us. From the Hôpital St. Louis, at Paris, a large collection of models and drawings had been sent. Some of these, in excellence of execution, were unsurpassed by any that I have ever seen. I will briefly notice a few of the exhibits which interested me most, but shall not attempt to classify them apart from notes of cases seen in the hospitals, and other matters.

Influence of Exanthems in predisposing to Cancrum Oris.

Amongst those sent from the Surgical Clinic (Billroth) was one showing cancrum oris. The patient, as usual, was a child, and the disease was noted as occurring after variola. The frequency, or indeed the almost invariable precedence, of an attack of some exanthem-fever has been strongly impressed on my own mind. Almost all the cases which I have had to

* I am aware that one or two Continental cases have been published. In one common lupus co-existed; a fact of some interest for me.

† This disease was well illustrated by a series of beautiful drawings and models which Dr. Radcliffe Crocker had brought with him for a paper, but unfortunately they did not find their way into the Museum, and were exhibited only for a few minutes.

treat had followed measles. Here is another item of evidence casually offered bearing in the same direction. Not only does the specific virus of syphilis dispose to gangrenous affections, but all other similar forms of virus have in greater or less degree the same tendency.

Cancer of the Skin secondary to Cancer of the Stomach.

Amongst the pathological preparations in the Congress Museum was a series illustrating the form of secondary cancer of the skin which may occur in patients suffering from scirrhus ventriculi. The opportunity for seeing these specimens gave me the more pleasure because I have had, not very long ago, a precisely similar case. The facts of my own case are briefly as follows.* A man aged about fifty came to me with a large area of infiltrated and indurated skin on one side of his neck. It was of considerable thickness, and as hard as it could possibly be. In the middle of the patch was an island of healthy skin, quite soft and supple. There was not much papillary growth, and no tendency whatever to ulceration. I felt confident that it was a secondary and not a primary form of scirrhus cancer of the skin. On inquiry, the man told me that he had been long under treatment for what was diagnosed as ulcer of the stomach, and that he had nearly died from vomiting and hæmatemesis. He had been kept alive for several weeks by nutrient enemata. He had finally recovered so as to take and digest food, and had even regained his strength sufficiently to make another voyage as engineer on a packet to the Mediterranean. On returning from this voyage the growth in the skin of his neck made its appearance. His recovery had been so nearly complete that the original diagnosis of organic disease of the stomach had been abandoned. When I saw the condition of his neck I was inclined to fall back on that suspicion, although his stomach symptoms were for the time in abeyance. The sequel was very conclusive. A few months after I had first seen him his sickness recurred; he obtained admission into the London Hospital again, and there died. *The post-mortem showed extensive scirrhus of the stomach.*

* I will at some future time publish this case in detail.

The specimens which have induced me to narrate this case were contributed by Professor Kundart from the Institute of Pathological Anatomy. They consisted of a stomach which showed extensive carcinomatous infiltration, with ulceration extending from the pylorus backwards along the greater curvature, and of portions of skin from different parts showing various stages of scirrhus infiltration and growth. The first was simply a brownish discoloration with hardness. Next, in the centre of this, little indurations like minute cauliflower buds made their appearance. These buds grew, and formed by their confluence and growth masses more or less pedunculated, which showed no tendency to ulcerate. The largest of these growths (from the border of axilla) was as big as the palm of a large hand, and at its middle an inch high. It was made up of coarse papillary growths, and looked much like some forms of papillary mole, but a certain puckering at its edge showed that there was infiltration and contraction of the true skin, and revealed its true nature. There was no ulceration. I have been somewhat detailed in describing the features assumed by cancer of the skin when secondary to cancer of the stomach, because the conditions were very unusual, and because the occurrence is very rare. The peculiarities of all forms of secondary carcinoma are no doubt given in part by the organ from which the infective material is derived, and in part by that in which it is implanted. They thus present considerable variety, and their careful study becomes for purposes of clinical diagnosis of much importance.*

Tuberculous affections of Skin and Mucous Membranes.

The relations of various affections of the skin and mucous membranes to tuberculosis and to "Scrofula," and the special appearances which they may present for recognition, constitute one of the most important, and not the least difficult, of the topics of the day. I will put aside for the present the whole of the lupus group, and will speak only of certain cog-

* For the narrative of a very remarkable case, in which rapidly spreading cancer of the skin was secondary to some abdominal growth, see ARCHIVES, Vol. II. p. 121.

nate maladies which do not usually obtain that designation. On the screen devoted to drawings contributed from Professor Billroth's collection was one designated "Tuberculose der Mamma." It represented the two breasts of an adult woman, both of them covered by inflamed and swollen skin, which presented extensive ulceration in separate patches, with flabby granulations and dusky discoloration. Some of the ulcers at a little distance from the principal ones showed small sloughs in their centres. It was an affection of the skin over the mammæ, rather than of the glands themselves, and I was reminded on the one hand of scrofulous ulceration, possibly secondary to abscess, and on the other of those ulcerations of the legs in young persons which have recently claimed the interest of several observers independently, and which were first described by Bazin* under the name of "Erythema indurée des scrofuleux." Its symmetry proved its constitutional origin, and was exactly parallel with what we see in the case of the multiple ulcers on the legs to which I refer.

From Professor Lang's Clinic we had a model of a tuberculous ulcer of the glans penis. It showed an unhealthy, much inflamed ulcer which surrounded the meatus. It was large enough to receive the end of the little finger. The history and the microscopic examination would alone furnish the diagnosis. Any one not informed on these points would have taken the ulcer for an inflamed chancre almost in a state of phagedæna. It had its differences, but they were too minute for me to attempt to describe them. I have myself in two cases, both in men above middle age, seen ulcerations about the meatus which I diagnosed as scrofulous, or as closely allied to lupus. In neither was there the least suspicion of syphilis, and in both cure was obtained with difficulty by repeated cauterisation. Both occurred some years prior to the discovery of the tubercle bacillus. I must therefore leave the diagnosis as to tuberculosis in some doubt.

Dr. Lang was kind enough to give me privately the history of his patient. The diagnosis was made quite certain by the microscope. The man was the subject of tuberculous disease

* I am indebted to Dr. Colcott Fox for the reference to Bazin's description of this disease.

of the bladder and kidneys, and the ulcer in the meatus bore therefore the same pathological relation to the internal disease that tubercular ulcers of the larynx and tongue often do to pulmonary phthisis. It was the result of local infection. Dr. Lang told me that he had seen several other cases of tubercular ulcers on the glans penis, but none of them primary.

Supposed Tuberculosis-infection from prick of finger.

A specimen-model of what was called tuberculosis by inoculation was shown by Professor Albert, "Impf-tuberculose; verletzung und Infectionen mittels nadels-stiches." The forefinger, which had been pricked, was much inflamed, swollen, and dusky. In the finger-cleft was a secondary swelling, and another (a small abscess) on the back of the hand. A string of little infection-swellings (tending to abscess) extended up the forearm.

If my reader will refer to ARCHIVES Vol. IV., page 53, he will find a very similar case recorded, and I have the drawing of another from the hand of a butcher who cut his hand with a knife and subsequently had infection-abscesses not only in the injured extremity, but on the head and face. No one can doubt that in these cases the injury is the exciting cause of what follows. The site of the prick or cut is the part which first inflames, and from it the tendency to the formation of chronic abscesses and conditions allied to scrofulous lupus spreads. Clearly it is an infection-process. So far as that goes, I will not in the least dispute the correctness of Professor Albert's designation. But there may perhaps be still some room for debate as to whether such cases are instances of the implantation of bacilli at the time of the injury. In Albert's case it was a prick by a needle, in one of mine also it was a needle-prick. In neither of these is it very probable that the needle was laden with tuberculous matter. In my other case it is true that there was more risk, for the butcher might possibly have been cutting up tuberculous meat. I am, however, myself more inclined to suspect that the tubercular proclivities existed beforehand in the patient, and that the injury excited irritation only, and thus prepared the

tissues for their development. In other words, it may have been that bacilli or their representatives were already present, and waited only for inflammation-damage to permit their multiplication. The cases belong, of course, to the group of necrogenic lupus, with the clinical difference that they represent a more acute form of inflammation. Many cases of necrogenic lupus which in the sequel become very chronic and quiet, are, however, in their first stage attended by suppurative inflammation of a more acute type. I may also ask attention, as distinctive from the more usual sequences of tuberculosis, to the presence, in the cases under consideration, of excess of inflammatory swelling and the tendency to rapid formation of abscesses.

Description of the Skeleton of a Short-Limbed Dwarf.

In the Pathological Museum of the Heidelberg University I found a skeleton of unique interest. It was that of a short-limbed dwarf, or rather perhaps it should be described as an arrest of development of all the four limbs. It was remarkably like that of the "Norwich dwarf" (which I have described in the Pathological Transactions), but with differences which were of importance, as possibly affording some clue to the real nature of the influences at work in the production of these extraordinary skeletons. Briefly it may be said that in this Heidelberg specimen there was not the slightest trace of rickets, whilst there was abundant proof of deformities which appear to be out of relation with any constitutional malady of that class. Not a bone showed the slightest trace of bending. The ribs were slender but well-formed, and the pelvis, although small for the size of the trunk, was not in the slightest degree distorted. The skeleton was that of an adult, and so short that the top of the skull readily passed under my arm. The bones of the skull and trunk appeared to be of natural size and of perfectly normal development, the dwarfing was in the limbs only. All the long bones were very much shorter than normal. I had no opportunity for making exact measurements, further than that I ascertained that the radius was not more than 3½ inches long. All the long bones showed remarkable expansion of their articular ends, and overgrowth

in connection with the epiphyses. The ridges, &c., for the attachment of muscles were in many cases much exaggerated, but not in all. The shafts of the humeri and of the femora were in their middle thirds slender, perfectly straight, round, and smooth. So far from the ridges in these parts being in excess, they were less marked than usual. The bones of the forearm and of the leg were, however, whilst very short, somewhat thickened, and displayed coarse markings. Thus, for example, the tubercle for the biceps was at least three times its natural size. The carpus and digits showed very remarkable changes. Some of the carpal bones in the second row were anchylosed, with, if I remember rightly, union of two of the metacarpals. The metacarpals and the phalanges were all extremely short and thick. It appeared as if the digits could not have been more than an inch and a half long, and as if the hand had been more or less clubbed. Both feet were in the position of equinus, with slight tendency to varus. The os calcis was rather small, but the other carpal bones were as large, if not larger, than those of a normal foot. The metatarsals and all the phalanges were, as in the hand, very short and thick. The scapulæ were, as in the Norwich specimen, rather small and thin; but the coracoids presented a very remarkable condition which was not present in the former. Upon the ends of these processes was placed a bar of bone almost as long and as thick as the two last joints of a little finger. This bar sloped obliquely upwards and backwards, and downwards and forwards, resting by its middle on the coracoid, of which it formed part. The conditions, so far as I could observe them, were almost, if not absolutely, symmetrical. I have ventured to write the above description of them from notes which were taken very hastily, as I was much pressed for time.

Arrest of growth of the digits is, I believe, exceptional in dwarfs, who usually have full-sized hands and feet. So also are conditions approaching to clubbing of these parts. In the Norwich skeleton the hands and feet are well formed.

I confess that I do not see how the hypothesis of rickets, whether intra-uterine or post-partum, can be invoked to explain all the changes which I have described. An arrest of

development, in connection with some cause of which as yet we know nothing, appears to me to be the only suggestion.

Stomatitis in association with a fatal form of Skin Disease (Pemphigus Vegetans of Neumann).

In 1887 I read before the Medico-Chirurgical Society a clinical paper which described certain cases in which a peculiar form of sore mouth had been the precursor of a peculiar eruption on the skin and nails, and which, after a not very long course, tended to a fatal termination. Two of my cases had, however, after resisting all other treatment, been cured, and apparently saved from death, by the continuous use of opium. The eruption had in all cases been secondary to the sore mouth. In two cases it had closely resembled pemphigus, but with a remarkable tendency to the formation of papillary growths on some of the abraded parts. In some of the cases, however, these latter features had been quite absent, and the eruption on the skin had been but slight in amount and had differed but little from eczema. I gave the disease no name, but simply drew attention to its clinical features and to the extreme importance of the opium treatment. I was not at the time aware that any similar cases had been described, but not long afterwards Dr. Radcliffe-Crocker drew attention to the fact that Neumann, of Vienna, under the name of "Pemphigus Vegetans" had recorded examples of a disease in some of its features very similar.

Dr. Radcliffe-Crocker himself subsequently, in an able paper, brought before the Society the particulars of another case (fatal) illustrating the same combination of symptoms.

From the time that my paper was written until the present date, I have seen no additional cases which I should like to claim as belonging to the same category, nor, as far as I am aware have any been recorded by British observers. It was therefore with great interest that, during a visit to the wards of the Vienna Hospital, I saw another example of this peculiar form of sore mouth. The patient, who was a man of about thirty, had large patches on his lips and inside his cheeks, which were covered by a glutinous greenish pellicle. These

patches were abruptly margined, and the adjacent mucous membrane was congested. There was no history of specific disease, nor had any cause for the inflammation of the mouth been detected. It was not a severe case, the man being as yet in tolerably good health and wholly free from skin disease. The sores, however, were exactly like those which I had seen in my own cases, and they had as yet resisted all attempts at cure.

Professor Kaposi, under whose care the man was, gave his prognosis in the clearest terms. "Although," said he, "there is no skin disease as yet, an eruption will certainly follow. The disease will run its usual course and the man will die."

In connection with this peculiar malady it is desirable to remember that there are certain forms of common pemphigus which are attended by the formation of blisters and excoriations in the mouth. They are usually very severe cases and tend rapidly to death. In them, however, the character of the stomatitis is different, and the dermatitis is unattended by tendency to vegetation. It seems by no means improbable, however, that there may be some alliance as to cause between pemphigus and the cases under consideration. At the same time it may be open to doubt whether the name "pemphigus" is a convenient one for a malady which always begins with a sore mouth, and is by no means always attended by an eruption having any approach to a bullous character.

The Hospital for Diseases of Children at Nuremberg.

There is at Nuremberg a well-managed and not inconsiderable Hospital for Children. It was founded by Dr. Knopf, and is now under the joint superintendence of him and his son. I visited it with Dr. Erbstein, and was taken round the wards by Dr. Hasselberger, the resident physician. The latter had only recently vacated a similar post in Munich, in the hospital which has so long had the services of my friend Dr. Ranke. I was told (by Dr. H.) that at the Munich Hospital intubation has entirely superseded tracheotomy for all acute forms of laryngitis. Only in chronic cases, stenosis, papilomata, &c., is tracheotomy resorted to. Dr. Hasselberger told me that thirty-seven per cent. of

cases of diphtheria treated by intubation had recovered. At Nuremberg intubation is as yet only on its trial, and tracheotomy is still in favour. I was shown two children in whom the latter operation had been performed. In one of these one day had elapsed, and in the other three days. The latter patient appeared to be convalescent. In the former the child was still restless, with great distress from difficulty of breathing, and obviously in much danger.

The causes of Contagious Vulvitis in Young Children.

I was told that in several German towns there had recently occurred little epidemics of vulvitis in young female children which presented all the characteristics of gonorrhœa. Great interest had attached to the microscopic examinations. By one it was reported that a coccus exceedingly like the gonococcus had been discovered, and in another series of cases it was held that the microbe was not in any way to be distinguished from that of true gonorrhœa. The children who suffered were aged only from two to five years, too young for any probability of infection by vicious practices. It was believed that the real explanation was that the children had occupied the same beds with their fathers whilst the latter were the subjects of chronic discharges, and had been infected by the bed-clothes. It is also obvious that under such circumstances the mother might also very probably in turn become a source of danger, and that towels, cloths, &c., might yet be more frequent vehicles of contagion than the bed-clothing. I do not know whether the superstition prevails in Germany that if a gonorrhœa can be given to one who has never had it, the giver will lose it. This wretched creed in England sometimes leads to vilely selfish conduct, and to acts which, though not sexual, are yet criminal.

In the investigation of this class of cases (which occur occasionally everywhere) it is necessary to proceed with the utmost caution. The microscope has now given us the means (at least, so we hope) of distinguishing the cases of false gonorrhœa in children from those in which inoculation has really taken place. Even when gonoccoci are present, however, it is necessary to remember that they are by no means conclusive as to any

sexual act, and that several other possibilities remain for our investigation. Bitter injustice has not seldom been inflicted by the assumption that all contagions of this sort are due to criminal acts.

Lupus Vulgaris following Strumous Periostitis.

A very interesting example of lupus vulgaris was shown to me in the Nuremberg Hospital for Children (Dr. Knopf). The patient, a boy of ten, had his left hand with all its fingers covered with scars and still persisting lupus-infiltration. His ring-finger was shortened in consequence of necrosis of the metacarpal bone (soundly healed). On this forearm (left) was a very large patch of superficial lupus, and lastly there was one in the middle of the right cheek (flush-patch). He had also dense opacities in the left cornea from strumous ulcers. He said that he had suffered as long as he could remember, and it appeared likely that the whole had begun from the strumous periostitis of his metacarpal bone. At any rate the case illustrates the coincidence of two conditions typically strumous (ulcers of the cornea and necrotic periostitis) with lupus. It is to be added that great benefit had been obtained to all the patches of lupus from the injection of tuberculoid in very large doses. All crusts had been removed, and although it could not be said that the lupus was really cured in any one of its three sites, yet it was reduced to quiesence in them all.

There was another case of common lupus in this hospital, and a very severe one. Thus, judging from what I saw for myself in this hospital, I should not have supposed this disease to be so infrequent in Nuremberg as authorities tell us that it is.

On the use of Arsenic without Medical advice.

Dr. Lewin, of Berlin, the well-known pharmacologist, mentioned to me some interesting facts in reference to the internal use of arsenic for cosmetic purposes. He introduced the subject by a reference to the opinion which I published at the time of the Maybrick trial, that it was not usual for patients

to whom arsenic had been prescribed medicinally to become fond of it. I then said, and I am still of the same opinion, that there is in England no belief on the part of the public that arsenic is useful either for cosmetic or aphrodisiac purposes. With the exception of cases of psoriasis and allied eruptions in which its remarkable and unique efficacy has been discovered by the patient, we never in English practice meet with those who take it on their own responsibility. Usually the prescriber has to use persuasion to induce perseverance with a drug which is dreaded as a poison. Dr. Lewin assured me that the case was different in Berlin, and that there, not unfrequently, patients to whom it had originally been prescribed as a medicine, would develop a taste for it and refuse to leave it off. Young women, under the idea that it improved their complexions, would take it for years together. If such a creed obtained in England it is quite possible that similar results might ensue. Our maidens, however, as yet, have no such imagined knowledge, and there is amongst us no abuse of the drug by the public. As a matter of fact, I much doubt whether arsenic does, as a rule, improve the complexion in women, or act as a sexual tonic in men. If pushed in full doses, I believe that it often has the reverse influence in both directions, making the complexion muddy, the eye dull, and much reducing the virile appetite. A case which came under observation in Vienna, and which I shall mention hereafter, confirms Dr. Lewin's impression that there are cases of long continued use of arsenic without medical authority. In this case a girl, the subject of acne, had taken arsenic for many years regularly, and had induced keratosis of her palms and soles.

Infrequency of Lupus in Bavaria.

At Nuremberg, lupus is reputed to be not common in any of its forms. The same is said to be true of Munich and the whole of Bavaria. Nor is scrofula, or any form of tuberculosis of the skin, common. In connection with this it is interesting to note that pulmonary consumption is at least as frequent as elsewhere. I was assured by Dr. Epstein that these facts could be proved by the citation of statistics. In

Prague and through Bohemia, on the contrary, lupus is very common, and pulmonary consumption, although frequent, is not in excess.

Favus contagious in a Family.

I was told in Nuremberg of a family affected with favus. Five brothers and sisters suffered, and one of the subjects was an infant only ten months old. I asked at once, "Were they Jews?" "You are right, they were," was the reply. Here we have undoubtedly an instance in proof of the possibility of the contagion of favus when the opportunities of contact are frequent, close, and long continued. Favus is, as in England, a rare disease in central Germany, and there, as with us, its almost exclusive victims are the poorest of the Jews.

Infrequency of Ringworm in Nuremberg.

Ringworm of the scalp in children Dr. Erbstein assured me was quite rare, much more rare than tinea of the beard in adults. This statement was confirmed to me by several observers. Tinea versicolor of the chest in adults is reported to be common everywhere. Alopecia areata is said to be fairly common in Nuremberg. I was told the same in Vienna and Budapest. At all these places I was told that it was more common than ringworm. In attempting to estimate its comparative frequency, however, I may say that I did not myself see a single case of it in any hospital, whilst I saw several of favus, a disease reported to be much more uncommon.

The statements just made are based upon reports made in conversation. Dr. Beckh (of Nuremberg) was kind enough to give me his statistical reports of in-patient hospital practice for the last ten years. From them I collated the following table, which appears to show alopecia areata as an exceedingly rare disease. It will be seen, however, that it quite confirms the verbal statements made as to the rarity of other diseases of the tinea family (cryptogamic) and also of lupus.

A TABLE SHOWING THE FREQUENCY OF CERTAIN FORMS OF SKIN DISEASE AT THE NUREMBERG HOSPITAL.

Year.	Total of Skin Diseases. *a*	Psoriasis.	Zoster.	Urticaria.	Prurigo.	Sycosis.	Lupus.	Tinea Family. *b*	Alopecia.	Pemphigus.
1882	225	13	4	4	1	1	0	0	0	1
1883	174	7	2	4	2	1	0	0	0	1
1884	238	9	2	3	1	1	0	0	0	3
1885	178	11	1	1	2	1	1*c*	0	0	0
1886	182	4	4	0	1	5	1*c*	0	0	0
1887	287	10	3	3	0	2	0	0	0	0
1888	238	11	2	6	0	2	1*d*	1*e*	0	0
1889	216	10	2	7	0	1	1	2*f*	0	0
1890	269	19	2	5	1	0	3	2	0	1
1891	289	20	5	7	3	0	4	2*g*	0	0

a In the "Tinea family" I include favus, ringworm, and tinea versicolor.

b From the total, all cases of uncomplicated scabies are omitted. They usually numbered at least half of the patients treated.

c Probably the same case in the two years. It affected one hand.

d Of the face.

e A case of pityriasis versicolor.

f A case of favus and another of herpes tonsurans.

g Both cases of versicolor.

Prurigo (of Hebra).

Great interest is always felt by dermatologists visiting the Vienna Hospital in seeing examples of the disease for which Hebra claimed exclusively the name of Prurigo, and which he described as beginning in childhood and lasting the life through. By general acknowledgment such cases are seldom, if ever, seen in England or the United States. They appear also to be gradually becoming more rare in Austria. I saw two "typical examples" in Kaposi's Clinic. One was in a lad of 14, and the other in a man of 30. In both, according to rule,

the legs were most severely affected, but in both the whole surface, excepting the head and hands, was more or less involved. The present doctrine is that it depends upon a congenital peculiarity of the skin, sometimes hereditary, and not wholly unallied to ichthyosis. In the young child it may in some instances assume the features of an urticaria. It is very rare amongst those who are cleanly and well cared for. This opinion as to predisposition is exactly what I have myself held for many years. There remains, however, still some difference of view as to the importance, or otherwise, of exciting causes. It is taught that these are nowise necessary, and that the pruriginous dermatitis begins spontaneously. I have long held that the irritation of fleas or lice, or the occurrence of imperfectly cured scabies, or even of a neglected eczema, may each in turn be the exciting cause of prurigo. I do not believe in spontaneity of origin, and by this incredulity I explain the infrequency of the disease in the richer class, and amongst those who attend carefully to cleanliness and clothing.

Rarity of Pruriginous Affections in some Districts.

The rarity, not only of Hebra's prurigo, but of all pruriginous affections, in some parts of Europe, is very remarkable. Dr. Fiertz, of Zurich, assured me that there was no prurigo of any kind there, and at Nuremberg it was spoken of as very rare, and the statistical table given at page 138 confirms the statement.

Macular Ringworm of the Trunk, &c.

Neither in the hospitals nor in the museums did I see a single example of what is known in Paris and London as pityriasis rosea. The Congress Museum, however, contained two large models of a malady which, if not allied to it, at any rate presents certain resemblances, and which, like it, is very liable to be mistaken for syphilis. I refer to "macular ringworm of the trunk." This is a disease which no one would think of calling ringworm at first glance, and which does not make any approach to the formation of rings. It occurs to adults, and covers the whole trunk with spots and small patches which

are of a brownish or copper tint, which desquamate in their centres, and which look exactly like syphilis. This description applies closely to the two models to which I am now referring. I have seen not a few such cases in practice, and sometimes under circumstances which made the diagnosis unusually puzzling, since the patients were willing to admit the possibility of syphilis. I have often searched for the ringworm fungus, and have always been disappointed. The disease gets well readily under treatment by a mercurial ointment or by sulphur baths.

One of these casts bore the diagnosis (by Kaposi) of "Herpes tonsurans maculosus." The other, from Neumann's Clinic, was named "Herpes tonsurans." In the latter there was some tendency to coalescence of the patches and to a diffuse pityriasis condition, but in the former the skin between the patches was quite healthy. All English and French observers with whom I exchanged opinions on the subject claimed this latter as one of pityriasis rosea. This term is possibly used by some of us too freely, and is applied to cases which are by no means all quite alike. Still there can be no room for doubt that it does connote an eruption quite distinct from ringworm.

Recovery after Tetanus.

In the Budapest Hospital I saw a boy who was convalescent from traumatic tetanus. On asking, however, how long the interval had been between the injury and the first appearance of symptoms, I was told "three weeks." This information abated my curiosity as to what the treatment had been. It is precisely these cases, with unusually long intervals, which do recover. See ARCHIVES, Vol. IV. p. 85. The triumphs of treatment come when the interval is less than a week.

Shingles after Arsenic.

The resident physician at the Communal Hospital at Budapest, and Dr. Epstein, of Nuremberg, both told me (independently) that they had had a series of cases of herpes zoster from the medicinal use of arsenic. Both observers appeared to consider the connection between the two as well established.

Prevalence of Calculus in the Danube Plains.

I was shown at the Hospital for Sick Children in Budapest a collection of four hundred urinary calculi. They had been collected during a period of rather more than forty years, and thus indicated an average of about ten stone-cases in children annually. I was told that the patients came chiefly, not from the city itself, but from the peasant population in the plain of the Danube. I suspect that the facts mentioned indicate a much greater prevalence of stone in these parts of Hungary than is found in Austria or Germany.

Eczema Scrofulosorum (Kaposi).

The term Eczema scrofulosorum, which was applied by Kaposi to a disease illustrated by two excellent models, was new to me. The models showed the disease on the thigh and on the abdomen of a young person. On the thigh, a patch the size of the palm of one's hand presented an aggressive and abrupt edge, and there was some appearance of thin cicatrix in the centre. It showed an eczematous crust, but was evidently in a very chronic condition. It reminded me, though by no means very closely, of some conditions which I have ventured to name Eczema-lupus. On the abdomen the conditions were different. Here lichen papules of a dusky red tint were arranged in lines and constellations (not in patches and not in the least like any form of lupus).

Tuberculous Ulceration of the Skin of a Stump.

Under the name of Fungus Cutis, Dr. Riehl exhibited a model of a stump of a thigh after amputation near to the knee. It was from a young woman still an inmate of the hospital. I had subsequently an opportunity for seeing the patient. The amputation had been performed on account of pulpy thickening of the synovial membrane of the knee. There was no proof of tuberculosis elsewhere. Thus the probability seemed very great that the skin had been infected directly from the diseased joint. The skin of the stump is now covered by unhealthy chronic ulcers, "scrofulous" or

"lupoid" under the older designations, but in which I was told that bacilli had been found. The rods of the parasite were to be discovered with much greater ease and in far greater abundance than is usually the case in lupus. We may therefore take these ulcerations as conclusively and typically those of tuberculosis of the skin. They were very large and numerous, and in many instances considerable areas of cicatrisation had been formed in their centres.

Gummatous Enlargements in the Cauda Equina.

From the Institute of Pathological Anatomy Professor Kundart also sent two beautiful preparations showing multiple gummata in the cauda equina. I was indebted to Dr. Paltauf for the demonstration of these very rare specimens. In both, many cords of the equina were simultaneously affected. In one the enlargements were fusiform; in the other they were larger and constituted roundish or irregular lumps. In seeing these preparations the thought occurred to me that possibly some of the cases published by Robert Smith of Dublin in his magnificent work on Multiple Neuromata may have been of syphilitic origin.

Statistics as to Diphtheria and its Mortality at the Nuremberg Hospital for Children.

The prevalence of diphtheria in Nuremberg appears to have been of quite recent occurrence. This is a fact of great interest, since it not only coincides with certain others in our English experience, but it may be held to prove that the disease depends upon contagion for its extension, and not upon local conditions.

In the year 1881 I find one case under the name of croup and 3 under that of diphtheria, with only one death. Scarlet fever in this year counted 20 cases and 4 deaths.

In 1882 diphtheria was the cause of 3 deaths, and scarlet fever of 3.

In 1883 there were 3 cases of diphtheria and 2 deaths. There were also 3 deaths from scarlet fever.

In 1884 two deaths occurred from diphtheria and one from croup. No deaths from scarlet fever.

The report of 1885 is not in my possession.

In the beginning of 1886 one child was remaining in hospital with diphtheria. Eighteen boys and 31 girls were admitted. Twelve boys and 11 girls died. At the end of the year some remained in. In this year there was no mortality from scarlet fever, and only 4 cases were admitted.

In 1887 36 boys and 43 girls were admitted, and 18 boys and 15 girls died. Two of each sex remained in the hospital when the year ended. In this year the mortality of scarlet fever was only 4, the number admitted only 27.

In 1888 45 boys and 24 girls were admitted, 14 boys and 15 girls died, and 4 remained in. In this year only one died of scarlet fever, and only 14 were admitted. In this year 4 cases, all boys, are counted under the name of "croup," without any mortality.

1889 is the last year of which I possess any report. Four cases were in the hospital when it began, and 4 when it closed. During the year 28 boys and 32 girls were admitted, and 15 boys and 16 girls died. Scarlet fever had no deaths, and only 6 cases were admitted.

Thus it would appear that the disease began to prevail in 1885–86, having before that supplied only sporadic cases. Since 1886 it has maintained a high average, and I believe that it still does so. It seems certain that there has been no kind of connection between the prevalence of diphtheria and that of scarlet fever, a fact to which also our English experience bears clear testimony. The statistics appear to me to possess some interest, as affording material for comparison with English towns. The tables before me do not give any information as to treatment.

Recent Increase in prevalence of Diphtheria.

That diphtheria has undergone a remarkable increase in some Continental cities as it has recently done in London seems to be the general impression. Nor does it appear to prevail in short epidemics only, but rather to persist for years in the districts where it has once become common. I quoted

in my last number (ARCHIVES, Vol. IV., p. 19) the facts from St. Thomas's Hospital, showing the very large increase of tracheotomy cases during the last few years. I have just adduced some facts as to its increase in Nuremberg, collated from the Annual Reports which were given me by Dr. Beckh. It is this increased, and apparently still increasing, prevalence of the malady which gives such great importance to the consideration of its treatment.

For the following facts as to the death-rate in different years, first in England generally, and secondly in London, I am indebted to our Registrar's statistical tables :—

Death-rate from Diphtheria in England.

In 1855 the annual mortality per million from diphtheria was	20
In 1858 it rose suddenly to	339
In 1859 it had risen to the highest ever attained ...	517
After 1859 it declined gradually with irregularities, and in 1872 was only	93
In 1889 it had by gradual increase attained that of ...	189
In 1890 it was	179

In *London*, diphtheria had a mortality of 284 per million in 1859. After that year it decreased. Since the year 1877, when it was only 88, it has been gradually increasing, with very slight variations, until in 1887 it was 235 ; in 1888, 319; in 1889, 390 ; and in 1890, 330.

To state the same facts in another form, there were in *London* in 1882 a total number of deaths from diphtheria of 857 ; in 1883, 952 ; in 1884, 951 ; in 1885, 904 ; in 1886, 851 ; in 1887, 953 ; in 1888, 1,311 ; in 1889, 1,588 ; in 1890, 1,417. I take these figures from Dr. Gayton's Report to the Metropolitan Asylums' Board.

PLATE LIX.

PHAGEDÆNA IN INHERITED SYPHILIS.

I have placed these three portraits side by side in order to illustrate the differences in destruction of the nose from lupus, and from the form of phagedænic ulceration which occurs in inherited syphilis. All these patients had suffered from the latter malady, and in all the nose had been destroyed. As distinguishing the appearances from those produced by the ravages of lupus, we may note, first, that the destruction is much greater, and that the cartilage and even the bones of the nose have been involved. It is to be observed also that the healing has been complete, and that the margins of the skin near to the scars are perfectly healthy. In lupus this is scarcely ever the case, the adjacent skin almost invariably remaining more or less thickened. The entire absence of any tendency to relapse is also a very marked feature in these cases, the direct opposite being, as is well known, the fact as regards lupus.

The disease which causes the deformities illustrated in these portraits usually occurs in children from six to fourteen years of age, and, I think, more often in girls than in boys. These three portraits are all copied from photographs in my possession, and are all those of girls. The correct diagnosis of the disease is of the utmost importance, for it begins as a rather acute form of phagedæna, and, unless arrested by adequate treatment, destroys the parts very rapidly. The treatment consists in the administration of iodide of potassium, and the application, free and repeated if necessary, of some powerful caustic to the parts.

Fig. 1.

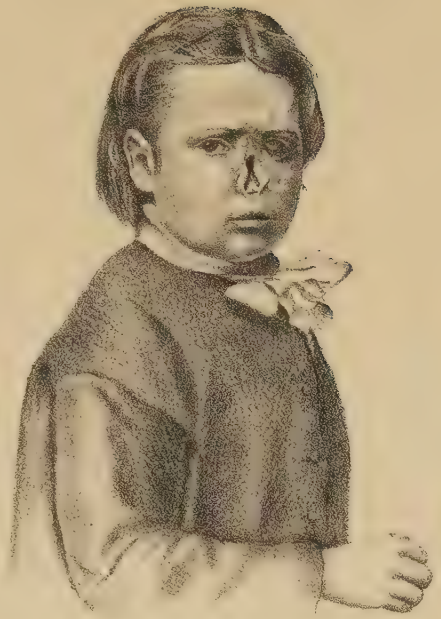

Fig. 2.

Fig. 3.

Inherited Syphilis.

West, Newman, lith.

SYPHILIS.

No. XXXII.—*Indurations in Lymphatic Trunks in possible connection with Syphilis.*

Most observers are, I have no doubt, familiar with the occurrence of little hard knots which form in the subcutaneous cellular tissue, and are often seen in apparent connection with syphilis. They are seldom round, but often bean-shaped, and there can, I think, be but little doubt that their anatomical site is the lymphatic trunks. They are, however, never attended by cord-like thickenings of long tracts, nor are the glands ever enlarged. They never in my experience run the course of gummata as regards softening or breaking down. Their usual course is to persist for a time and then disappear. Although most frequently seen in those who have had syphilis, they are met with occasionally without any such history. They are quite different from neuromata in being neither painful nor tender. They differ from "rheumatic nodules" in that they are usually, although multiple, quite isolated, and show no preference for any special localities. They are not very usually met with on the hands or feet, nor near to subcutaneous bones. They may, however, be found on any part of the limbs or trunk. In some instances there may be a suspicion of gout.

An example of these peculiar indurations occurred in the person of a surgeon, Mr. H—— H——. He was thirty-three years of age, and had suffered from syphilis four years ago, for which he took mercury for a whole year. He appeared to have been quite cured, and at the time that he consulted me he had no indications of syphilis about him, unless these little indurations were to be counted as such. He was of very

dark complexion, and apparently in good health. He was losing his hair. His father was, he told me, very rheumatic, but he did not think that he had ever had a definite attack of gout. He had himself suffered at times from rheumatic stiffening of joints. The indurations about which this gentleman was anxious occurred on his hands, forearms, and feet. The largest was not so big as a pea, and most were about the size of shots. They were very superficial, and although apparently not beginning in the skin itself, they became at an early stage inseparably united to it. They were most of them of an elongated or oval form, with indefinite boundaries. He stated that they were not persistent, but that some would disappear and others come. They gave him not the least pain, and never showed any tendency to inflame. I advised him to rub in some mercurial ointment over the little "knots" three times a day. After two months' treatment by this, without any internal medicine, he called on me again. Several of the knots had melted away, but several still remained. One in particular near his left elbow, which had formerly been adherent to the skin, was now quite loose beneath it. He was quite clear in his opinion that some of them had previously disappeared independently of treatment.

No. XXXIII.—*On Phagedæna in Second contagions of Syphilis.*

I find in some surgical notes by Sir Astley Cooper an observation which supports what I have often remarked, namely that phagedæna often attacks the chancres of those who have suffered from syphilis before. "Mr. C—— had a chancre upon a penis previously diseased by chancre. This fresh chancre put on a sloughy appearance, and extended into the urethra, and it seemed to be the use of mercury which occasioned this state." The notes record that there was at first definite sloughing and afterwards phagedænic ulceration. Mercury on two occasions seemed to provoke a relapse of the sloughing, but so also did opium. It was a troublesome case, but finally got well under "sarsaparilla wine and black wash."

No. XXXIV.—*Chancre of the Nail followed by general Onychitis.*

Dr. M——, a surgeon, who consulted me with a chancre of the nail, in June, 1891, had during the secondary stage inflammation of all his nails, both fingers and toes. The nail of one of his great toes was for a time much inflamed. When I saw him in May, 1892, all the nails had grown again perfectly, excepting the one involved in the original chancre. This was in a condition of scar, much reduced in size, thin, and fluted.

I add this case to a number of others which I have previously recorded, which seem to show that secondary affections of the nails are very prone to follow chancres of the nail.

No. XXXV.—*Molluscum Contagiosum mistaken for Syphilis.*

Three years ago I saw an infant in consultation for symptoms suspicious of inherited syphilis. Its father strongly denied that he had ever had any venereal disease, and I believed him. A few days ago he came to me in much distress, saying that he had broken out in spots, and that he feared that after all, although he could not explain it, the suspicion which had been expressed must have been correct. I found, on stripping him, that he was covered with the little buttons of molluscum contagiosum. He was, as is usual when adults become the subjects of this malady, a frequenter of the Turkish bath. He said that his wife had also got a few spots.

No. XXXVI.—*Recrudescence of a Secondary Syphilitic Eruption—Papules developed in pairs.*

A very intelligent patient, suffering from a secondary syphilitic eruption, made a curious observation which I think worth recording. His eruption had shown a tendency to relapse (under inefficient treatment), and he noticed that the spots came, as he expressed it, in doubles. This he demonstrated to me. Everywhere there were two spots in close juxtaposition,

one being, by estimation, two weeks or so older than its companion. His eruption had occurred sparingly on all parts of the limbs and trunk, and the phenomenon in question was easily observed. Two explanations might perhaps be suggested. First, that a recrudescence of the syphilitic fever tended to produce a fresh symmetrical outbreak, and that the spots being unable to develop exactly on the parts already in possession, came out as near to them as might be; the other, and I think the more plausible, that the original spots infected the tissues close to them, and thus during a general recrudescence took an important share in locating the fresh eruption. So far as I know, the observation is novel.

No. XXXVII.—*On the use of Specifics internally in the treatment of Phagedæna.*

It was, I believe, a very general opinion of the older writers on syphilis that mercury was unsuitable in cases of phagedæna.* There are, however, so many fallacies, that trustworthy observation becomes very difficult. This was, I think, well illustrated in a case which I reported not long ago (Archives). Phagedæna is in the main a local process, and is influenced chiefly by local treatment. It may occur to healthy persons, and wholly without reference to the previous use of mercury. Very often, as above stated, it happens to those who have had syphilis before. In all cases the surgeon is compelled to employ a complicated treatment, in part local and in part constitutional, and it is often almost impossible on this account to tell whether any one element in the treatment has been prejudicial or otherwise. My own belief is that it is usually wise to combine with the most vigorous local measures the use of specifics—mercury or iodides, or both. At any rate, of this I am sure, that I have seen many cases of severe phagedæna cured whilst the patient was taking

* "For phagedenic primary ulcers I have always found mercury most injurious. They are most successfully treated by the application of strong nitric acid, immediately followed by a douche of cold water. The same application is also the most efficient for phagedenic ulceration of the throat, which if not checked will soon extend over the velum, uvula, and back of the pharynx." —From an address by Mr. Carmichael, 1834.

specifics freely. If, however, you trust to them and neglect local measures, it will be easy to come to the conclusion that they are very harmful.

No. XXXVIII.—*On the comparative efficacy of Mercury and Iodides in the treatment of Periostitis.*

A case in conclusive proof of the superior efficacy of iodide of potassium in competition with mercury for the relief of syphilitic periostitis came recently under my notice. It went even further than this, and proved that in some instances at least mercury is of no use whatever against syphilitic bone disease. A gentleman, who had come over from Australia for treatment, had suffered from periosteal enlargement of the lower end of one tibia for three years. During the whole of this long period he had kept the disease at bay by taking iodide of potassium. Doses of ten grains each, three times a day, always sufficed to reduce the swelling and take away pain. Invariably, however, if he left off the remedy for more than a week or two, aching returned and swelling increased. The enlargement of the bone was so considerable and so definitely local, and the persistence of the disease had been such, that I was led to advise trephining of the affected bone. Before doing so, however, as he had not recently taken any mercury, I determined to prescribe that remedy. The dose given was two drachms of the solution of the bichloride (gr. $\frac{1}{8}$) three times a day. A fortnight later my patient returned to me with the statement that my prescription had not given him relief as his old one used to do. On the contrary, his node had swelled and become painful whilst taking it, and he had been obliged to leave it off and fall back on the iodide. The latter had immediately, as heretofore, taken away both pain and swelling.

No. XXXIX.—*Syphilitic Lupus closely resembling Lupus Vulgaris.*

An interesting example of a lupoid affection from syphilis after a very long period of immunity, occurred in the case of

Mr. H. S——. He was 39 years of age, and came to me for what he called eczema on his arm; it was, however, a well-characterized group of lupus spots. There was no ulceration; the only question was whether it was syphilitic lupus or vulgaris. The spots were arranged in irregular crescents, and had much the appearance of apple-jelly with very slight thickness. I found that he had a patchy tongue of a very suspicious appearance, and on inquiry found that he had been treated for syphilis twenty years ago in Paris. With the exception of his tongue, to which he had paid no attention, he had not had any reminders.

No. XL.—*Three Indurated Chancres (with eight years intervals) in the same patient.*

A barrister, Mr. R——, aged forty, was brought to me by his medical attendant in April, 1892, on account of a distinctly indurated chancre in the roll of the reflected prepuce. It was quite possible that it was the result of fresh contagion, but it was possible also that it was an instance of recurred chancre, for it was exactly in the site, as he believed, of a former one. It had been present for several weeks, but as yet no definite secondary symptoms had occurred. It must be remembered, however, that Dr. R—— had already given some mercury. It was a long crescentic ulcer, with very hard edges.

Mr. R—— told me that he had consulted me on a former occasion, and on turning up some notes made in October, 1883, I found that he had then told me that he had been treated eight years previously for what was said to be an indurated chancre by a well-skilled surgeon at Cambridge. He escaped secondary symptoms. When he came to me on October 9, 1883, he had a sore of five weeks' duration, on which different authorities had given different opinions. I felt no doubt that it was specifically indurated, and advised him to take mercury. This was done, and a month later all induration had vanished, and no secondary symptoms had followed.

Thus we have an instance of three occurrences of indurated

chancre in the same patient with two intervals of eight years each. On the first two occasions mercury was given, and no secondary symptoms occurred. The third is still under treatment. In each instance fresh contagion was suspected. It seems most probable that the first attack was true syphilis well cured, and that the two later were really fresh infections, the results of which were modified by the first attack.

No. XLI.—*Hemiplegia with early Syphilis.*

I saw, with Dr. L——, at Hampstead, in January, 1891, a case of hemiplegia in a very early stage of syphilis. The patient, a young Spanish gentleman, had been treated in the previous November for a chancre at the meatus and gonorrhœa; he had also a chancre in the frænum. One of the sores became phagedænic, and Dr. L—— had him admitted into a hospital and treated him by inunction. He had a sore throat, but no eruption ever showed itself. The inunction had been pushed to ptyalism, and had then been wholly suspended. Thus it was only three months from the chancre, and only about three weeks after it had healed and the treatment been left off, that the hemiplegia occurred. The symptoms which attended the onset of the hemiplegia were somewhat peculiar. Mr. —— attended a public meeting for which he had to act as reporter. This was on the evening of January 20th. On leaving the room he did not feel quite well, but he got home and went to bed. He had not previously suffered from headache, or had any cerebral symptoms. On waking in the morning he felt uncomfortable in his head, but, to use his own expression, "I managed to crawl downstairs to breakfast." He felt giddy, and could not walk well. On reaching the breakfast parlour he sat down in an armchair and went to sleep. After a short nap of perhaps ten minutes he awoke, and found that he could not use his left arm and leg, and could not stand. The right side of his face was also paralysed. He was taken upstairs to bed, and Dr. L—— was sent for. The hemiplegia was not by any means complete, but the limbs were very decidedly weak. Improvement soon began to take place, and when I saw him three days

later the lower extremity had almost entirely recovered, and the upper one was only slightly weak. He could frown with the whole forehead, but did not use the right side of his cheek well. He had no pain in his head, nor any defect of hearing or of sight; there had been no obvious weakness of his sphincters.

On the supposition that the hemiplegia was probably due to arterial disease, the mode of onset was certainly exceptional. It is not easy to see how the threatened, and partial, blocking of an artery should have caused the tendency to go to sleep; yet no doubt the theory of arterial obstruction is the most probable one.

PLATE LIV.

CANCER OF UMBILICUS.

In this Plate are shown the conditions which were present in a case of cancer of the umbilicus. The patient was a lady of about 50 years of age, who had noticed a warty nodular growth on her navel for two or three months, and who was considerably out of health. As there did not appear to be any conclusive evidence of the existence of primary disease elsewhere, I thought it best to excise the affected part. This was done by cutting through into the peritoneal cavity, and taking away the elliptical portion shown in the left-hand figure. The peritoneal surface was found to be unaffected, but the scirrhus growth adhered to it. An incision from below into the indurated part displayed the section which is shown in the right-hand figure. The patient recovered well from the operation, but within two months of its performance there was evidence of nodular induration of the liver. Great irritability of the stomach supervened, and death from cancer of the liver followed about four months after the operation. Having regard to this sequel, I have little doubt that the primary disease was in, or near to, the liver itself, and that the growth on the umbilicus was a secondary one. The infection was probably carried directly by lymphatic trunks passing along the cord. I have had two other cases in which a malignant growth, making its appearance at the umbilicus, was really secondary to disease in the liver. In one of these a very remarkable tendency was subsequently displayed for the infection to travel along the lymphatic trunks. The disease spread downwards, on both sides, in the abdominal wall as indurated cords, and caused enlargement of the inguinal glands.

PLATE LIX.

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West, Newman, chromo.

DISEASES OF THE SKIN.

No. LXX.—*A Papular Eruption following Measles in a Young Infant—Tendency to Gangrene—Long persistence.*

In March of 1883 I saw the infant child of a Mrs. S——, who lived in Vauxhall. The baby appeared to be in good health, but had been for three months the subject of an almost gangrenous eruption which occurred in scattered spots, looking remarkably like those of variola. This eruption was said to have followed immediately after measles, but as has just been stated, it had existed for three months. The infant had been taking medicine all the time;—whether it had taken bromides or iodides I could not ascertain. The eruption was said to have commenced on the hands. I possess two excellent drawings illustrating this case, one of them showing the chin and lips, and the other the backs of the thighs. The eruption was remarkable for the sameness of its character in all parts. It consisted of flattish papules arranged somewhat in groups, almost all of which had ulcerated, and presented greenish yellow crusts. The papules were at their bases vividly congested, but there was not the slightest tendency to diffuse dermatitis, the skin being in other respects pale and healthy. It could not be said that there was actual gangrene in any of the spots; that is, the skin had not sloughed in fragments of appreciable size. Clearly, however, a process closely allied to it had occurred. The eruption affected the chin, neck, and scalp, the arms, insides and backs of thighs, and the popliteal spaces. It appeared to prefer the flexures. There were a few scattered spots on the trunk. The prolabia

of both lips were affected, but, with the exception of the chin, the face had almost wholly escaped. On the lower extremities and neck many of the papules had no crusts. They were considerably raised and almost the size of split peas, looking much like those of small-pox or even suggesting a comparison with molluscum contagiosum. On the scalp the secretion was more free and the papules were less marked, the conditions somewhat resembling those of porrigo or impetigo contagiosa. The infant had a brother, aged four, living in the same house, who was free from eruption.

I must not by any means claim this as a case in which the eruption of measles became gangrenous. It seems, however, not improbable that the previous occurrence of measles gave peculiarity to the morbid processes, rendering them more prone to molecular gangrene. It appears to me probable that the case was one of a locally contagious inflammation allied to porrigo, which took its peculiarities from the immediately previous occurrence of measles.

I am not able to state anything as to the sequel of this case. The child, I believe, ultimately recovered. The case differs from most other forms of multiple gangrenous dermatitis in its chronicity. In gangrenous vaccinia and varicella the process is a rapid one, and either the child soon sinks under the irritation or the sloughs separate and the sores heal. In this instance the papules had persisted three months. In the last number of Archives I quoted from the St. Bartholomew's Hospital Reports the case of a child who had gangrenous dermatitis after typhoid, and stated reasons for the general belief that all the specific fever-poisons give tendency to gangrenous inflammations.

No. LXXI.—*Epidemic prevalence of Ulcerated Navel in Infants.*

At the Lyons Hospice de la Charité in 1857 ulceration of the umbilicus in new-born children prevailed as an epidemic. It caused the falling of the cord to be delayed, and produced sores which healed with difficulty. The sores were finally cured by chloride of zinc.

I mention this occurrence because it is of interest in connection with the epidemics of porrigo in infants which I recorded a few months ago. It is almost certain that the Lyons cases were due to some contagion conveyed inadvertently by the nurse in attending to the navel. It is important to observe that all the cases appear to have been alike, and they were not attended by other affections.

No. LXXII.—*On Sclerosis of Skin in the Coccygeal Cleft.*

Mr. K. S——, aged 65. He has had it more or less some years. The whole cleft is now hard and horn-like. It has itched somewhat. He has hard, rough, ill-defined patches in flexures of knees. In his occupation as engineer he is obliged to kneel occasionally. On his knuckles the skin is a little rough and thickened. He is in good health.

Once in hot weather he had a little eruption of red spots in his hands, which, however, soon went away.

This condition appears to be distinctly senile. I have never seen it in young persons.

No. LXXIII.—*Distension of Glands in the prolabium of Upper Lip.*

Every one is familiar with the appearance, in the buccal pouches, of long rows of yellow points produced by enlarged glands.

A surgeon, aged 30, consulted me with a similar state in the prolabium of his upper lip. It was not seen till the lip was everted, and was then very conspicuous. It extended with some imperfect breaks the whole length of the lip. The band was not wider than an eighth of an inch. The separate glands were easily distinguished though close together. He had been treating his lip for eczema, but as there was not the slightest irritation or discharge or peeling I advised him to let it quite alone. He was a smoker. There were no spots in his cheeks, but a few in the prolabium of his lower lip.

No. LXXIV.—*Long persisting liability to sores on the lips and in the mouth—Ringworm tongue—History of the same conditions in several members of the family.*

A gentleman named B——, aged 54, consulted me in January, 1889, and again in March of 1891, on each occasion on account of a sore mouth. His account was that he had been liable to ulcers in the mouth more or less all his life, and it appeared that he had often suffered from herpes on his lips. He told me that his mother, a sister, and a brother had all also suffered from sore mouths. His sister, who was ten years older than himself, had suffered many years in succession, and very severely, and had been accustomed to go to Royat for its cure. When Mr. B—— came to me in 1889 he had numerous ulcers in his mouth and some herpetic sores on his tongue. His account of the persistence of the sores for considerable periods was inconsistent with the diagnosis of ordinary herpes. It was clear, however, that he was liable to sudden exacerbations. He was a smoker, and accustomed also to drink effervescents. He considered that all his family were more or less gouty. He was almost an abstainer as regards stimulants. I advised him to abstain from smoking and all sources of irritation to the mouth, and I believe that I did not see him again for two years. On the 7th of March, 1891, he consulted me, with a history that although he had been better he had never been well for long together, and he had now a very definite relapse. The condition now assumed was one of ringworm-like patches on the sides of the tongue. These presented bald areas with filmy white edges. The mucous membrane of his lips was much congested. Three weeks later he returned with a large ulcer on the mucous membrane of the upper lip. It had a florid edge, and was covered with a coherent pellicle which could be peeled off. It was exactly like the sores in the case of a gentleman from Dorset which I published some years ago.* He had, however, never had any skin disease. I now prescribed for him Battley's solution of opium in three-drop

* In "Medico-Chirurgical Society's Transactions."

doses, nux vomica, and cascara. Under this treatment, a week later he came with his lip very much less inflamed and the sore healing. Subsequently the lip got quite well, and the state of the tongue and the mouth generally was much better. He stated that under the opium he felt quite a different man. He had before felt heavy and low-spirited.

On August 24th, five months after the last note, Mr. B—— came to me again. He said that although he had quite left off smoking, and disused his artificial teeth, he could not get his mouth quite well. He had just returned from a six weeks' stay at Royat, where his tongue had been worse rather than better. He now told me that two of his children (of whom he had nine) suffered from tongues much like his own. Thus we had evidence of its occurrence in three generations. His own tongue was at this date as characteristically that of "ringworm" as any that I ever saw in a child. The patches changed their place frequently and were abruptly margined. In addition to this state of his tongue he was still liable to recurring sores, probably of an herpetic character, on his lips and cheeks. These never attained any great severity, and usually got well spontaneously in the course of a few days.

It seems probable that we have in this case an example of hereditary tendency to a recurring form of stomatitis; of this, one chief feature is the abruptly-margined patches known as "ringworm of the tongue." In the case of Mr. B—— himself, and probably also in that of his sister, this condition of the tongue appears to have been complicated with some herpetic tendency as regards the lips, &c. The ulcerations on the lips, however, showed a tendency to persist which is unusual in herpes. At one period Mr. B——'s mouth much resembled the conditions which I described some years ago, and which were curable by opium. Mr. B——'s sister, whom I never had the opportunity of seeing, was believed to have derived great benefit from the Royat waters, which contain arsenic. Mr. B—— himself did not improve at all under them, nor did the arsenic which I prescribed medicinally effect a complete cure. My impression is that he derived great benefit both from opium

and arsenic, but up to the date of my last seeing him they had not succeeded in effecting a complete cure.

No. LXXV.—*Catarrhal eruption on the limbs of erythematous character—Recurrence twice a year for seventeen years. (Peliosis Rheumatica?)*

Dr. Rolleston, of the Metropolitan Hospital, was good enough to send to me a man who had presented himself in his clinic, and who told him that I had formerly taken much interest in his case. The man was a coachman aged 45, in fairly good health, but nervous. His ailment was a recurring erythema of the limbs, the attacks of which were of short duration and disappeared spontaneously. It was for one of these which he had gone to the Metropolitan Hospital, and it had disappeared absolutely when he came for inspection to my house about a week later. I have not been able to find my notes of his case, nor have I any recollection of it, and the following statements are taken from what the man himself told me. He said that about seventeen years ago he was admitted into the London Hospital under Dr. Stephen Mackenzie's care for rheumatism, which he believed he had caught from sleeping in a damp bed. Whilst recovering from this he came out in a profuse eruption, and for this Dr. Mackenzie requested him to see me. He states that I gave a clinical lecture on his case in the theatre of the hospital. I have no doubt it was an example of what I used then to call purpura thrombotica, and which is frequently termed peliosis rheumatica. It affected the limbs only, and after lasting a short time entirely disappeared. Since that time attacks have occurred with tolerable regularity twice a year, in the spring and autumn. They have seldom lasted more than a week. The eruption is described as coming out very suddenly. The man states that sometimes in the course of twelve hours his limbs will be "smothered with an eruption of scarlet and blue patches." It is attended with some little feverishness and discomfort, and sometimes with rheumatic pains. The trunk is seldom or never affected, and the eruption disappears from the limbs in the course of a week.

It would seem probable that in this case the eruption should probably rank as of a catarrhal character. It recurs much at the same intervals as persons are liable to ordinary catarrhs, and it disappears as catarrhs do, almost spontaneously.

No. LXXVI.—*Very extensive and severe Scrofulous Disease in Childhood—Complete recovery (with deformities).*

I saw recently a case of much interest in reference to the occurrence of scrofulous abscesses in infancy. The child was vaccinated at three months, and all did well. Three months later an abscess formed in the left cheek, in the middle of the flush patch. Soon after other abscesses in various parts followed—under the chin, on the forearms, legs, fingers, and feet. She was for many months under surgical care (Mr. Pearce Gould and others) and her ailments excited much interest. From both thumbs fragments of bone from time to time came away. So extensive was the disease of the left arm about the elbow that it was thought that any recovery of a useful member was beyond hope.

The feature of chief interest in the case is the completeness of the recovery. The child is now a very healthy-looking, florid girl of ten. She is, perhaps, a little less than the average height of her age. Not a trace of active disease remains. All the ulcers have now for some years been soundly healed. She is, however, covered with scars. There is a deep one in her left cheek. Her left arm shows six or seven large ones, but they do not cripple the elbow in the least. She has perfect use of the extremity, with the exception that the thumb has been practically lost. Her thumbs are in the condition of being mere stumps, consisting only of the nail and pulp placed on the end of the metacarpal bone. The two phalanges have been lost by necrosis. She can oppose the stump of the right feebly, but that of the left is of no use. There are other scars about the hands and digits, but they do not involve disability. The fronts of her legs present large superficial scars.

The scars are those usual after strumous disease of cellular tissue, and wholly different from those of lupus. They are white, quite sound, and supple, abruptly margined, and in many places the fact that the ulcers were undermined is proved by the presence of almost pendulous nodules, or long rolls of elevated skin. (These need trimming.) No induration remains at the base of any of the scars with, perhaps, the exception of the one under the chin which is a little thickened.

It does not appear that there was ever any affection of the glandular system. The disease appears to have been restricted to the subcutaneous cellular tissue. It was not a disease of the skin. In the case of the thumbs it extended deeply to the periosteum and caused necrosis of bones, but nowhere else have joints been involved. The elbows, although surrounded by abscesses, were not involved, and their movements are still perfect.

The case illustrates the following points :—

Strumous abscesses may prove infective and become multiple.

Strumous disease of cellular tissue may keep for the most part to the tissue at first involved.

Strumous disease of cellular tissue may from proximity involve the skin extensively, and the bones in certain parts.

The recovery from very extensive, infective, strumous inflammation may in the end be very complete.

The lymphatic system is not prone to suffer in strumous suppuration of cellular tissue.

Acute and very severe struma in childhood does not always involve damage to the general health.

Strumous disease of cellular tissue is a malady wholly distinct from lupus.

To the practical surgeon such a case is of the utmost value as giving guidance in prognosis, and encouragement to persevering treatment. Especially does it teach a lesson as to the avoidance of amputation. I am informed that the question of amputation was often discussed, not only in reference to the thumbs, but as to the left upper extremity itself.

I had not much opportunity for going into the family history; the mother had been told that the disease was due to

vaccination, and, although she scarcely believed this herself, she was unwilling to admit anything as regards family tendencies. She was herself a florid, fairly robust-looking woman, and she had several other children.

No. LXXVII.—*Vaccinia Eruption resembling Variola.*

I have seen, during the last few months, two examples of a vaccinia eruption which looked exactly like variola. I have also been made acquainted with the particulars of two other cases, and am thus led to suspect that the event is not perhaps very uncommon. By a vaccinia eruption, I of course mean an exanthem—a symmetrical and constitutional eruption—occurring during the febrile period of vaccination. It usually comes out from the sixth to the ninth day simultaneously with the full development of the vaccination pocks. That some form of general skin eruption does not unfrequently occur at this stage has long been known to observant vaccinators, although ignored or even denied by others. Usually it is a slight affair, a mere erythema, or a crop of small transitory vesicles. The important peculiarity of the cases to which I now refer is that the eruption assumed the features of variola. The spots were in the first instance hard and shotty, and there next developed upon them large round umbilicated vesicles, which would have been regarded as most typical had they occurred as part of a small-pox eruption. They were sparingly scattered over the limbs and trunk. The two patients whom I have seen were both of them under the care of Dr. Colcott Fox, to whose kindness I was indebted for the opportunity of examining them. In each of these the infant was very young, and had been vaccinated from arm to arm in a Maternity Institution. In both the arm was very much inflamed. There had been no known exposure to the contagion of small-pox, nor did any spreading from these infants takes place.

The appearance of variola-like pustules as a vaccinia eruption is of great importance as an item of evidence in support of the belief that vaccine lymph is a modification

of the small-pox poison. Pustules, such as were produced in the two cases to which I have referred, are never seen excepting either in variola or in vaccination itself. It is a most interesting fact that, although vaccinia appears to be thus competent to produce an eruption like variola, it does not generate a malady capable of spreading by infection.

LXXVIII. — *Mercurial Erythema and Mercurial Eczema.*

We know but little in the present day of the disease to which our predecessors used to give the name of Erythema Mercuriale. So strong was their conviction that this disease was due to the drug, that it was thought worth while to record cases which were exceptional, and in which no mercury had been used. One such is given by the late Dr. Rutter, of Liverpool. He records that he saw the patient through an acute attack which lasted three weeks, and which affected the genitals, abdomen, limbs, head, and face. It was not a simple erythema, for there was much discharge of an offensive odour (seborrhœa). It had apparently begun as balanitis. The patient had on this occasion not taken any mercury. He, however, gave the history of a precisely similar attack seven years before, which had been apparently produced by salivation for a gonorrhœa.

The following is Sir Benjamin Brodie's account of what he called "mercurial eczema." I take the extract from the paper which I have already quoted from :—

"Some persons are subject to a peculiar cutaneous eruption while they are taking mercury; this is named the mercurial eczema; sometimes it shows itself only on the inside of the thighs, extending from the upper part near the scrotum, to about the middle of the limb. In some cases it extends over the whole body, and may go off in about five days; but sometimes at about that period, you find the skin covered with vesicles, which in time burst, and the cutis beneath them looks red and raw, and secretes an ichorous fluid; the cuticle and the fluid dry together, forming bran-like scales, which fall off, and give place to another set.

Sometimes this peculiar eruption will go on in this manner for some weeks."

One explanation of the greater frequency of eczematous eruptions during secondary syphilis in former days may possibly be that inunction was more frequently employed, and perhaps somewhat more roughly, than is at present the case. We still, however, every now and then see cases of severe and general eczema in connection with syphilis which cannot be so explained. I have in memory three or four such. They usually partake of the nature of erysipelas-eczema, and I am inclined to regard the condition as an accidental complication rather than as a part of the syphilitic malady.

LXXIX.—*A Case of Acute and Universal Erysipelas-Eczema in the course of Secondary Syphilis.*

A case illustrating the occurrence of acute universal dermatitis of the eczema type in the secondary stage of syphilis was seen by me about two years ago in consultation with Dr. Kibbler, of Hackney. The patient, a lad of two-and-twenty, had contracted an indurated sore, and had an eruption come out at about the end of the eighth week. He took some mercury and some iodide of potassium, and Dr. Kibbler thought it possible that it was under the influence of the latter that the eruption had changed its type. If it were so, however, it is certain that the eruption did not subside on leaving off the drug, but continued to develop into a far more acute disease. It finally assumed the type of an erysipelatoid eczema, and spread over the whole surface with œdematous swelling which entirely prevented the use of his hands and concealed the features of his face. During this illness (which had kept him in bed for a fortnight when I saw him) he had high temperatures and much general disturbance.

When I saw Mr. R—— (on March 7, 1891), although somewhat improved, he was still in the most deplorable condition. His head and face were so swollen that he could only just open his eyes, and his chin and cheeks were covered with greenish purulent crusts. On his hands there were many abortive vesicles and small pustules. The whole of his chest

and abdomen was covered with patches of a sort of lichenoid eczema of a dusky red tint, and so extensively confluent as to involve almost the whole surface. His upper and lower limbs were in a somewhat similar condition. His digits themselves were scarcely affected, the condition appearing to be one which was travelling from the trunk downwards. There was no mercurial fœtor, nor were his gums much swollen, but their edges were inflamed and secreting pus. At this date his chancre had for some time disappeared, and he had no ulcers in the throat. He had not taken either mercury or iodide for more than a fortnight. He had not, as far as he knew, ever been liable to skin disease before the attack of syphilis.

The question occurs in this, as in some other cases, as to whether the eruption ought to be counted as an erysipelatoid eczema due to one or other of the remedies which had been employed.

PLATE LV.

SUMMER ACNE.

Amongst the eruptions, which, although not wholly produced by summer are yet much aggravated by it, we have a form of pruriginous acne. This disease is well illustrated in one of the New Sydenham Society's portraits, and I have described it under the name of prurigo æstivalis. It is especially common in young persons, and particularly in young women. The eruption is almost always worse in hot weather, and gets almost or quite well in winter. The liability to this form of summer acne in most cases ceases between the 20th and 30th year.

The portrait which I now give well illustrates this malady as it occurred in a lady of middle age who had been liable to it almost from girlhood. She was in excellent health, but her face, neck, and the backs of her hands were, as is shown in the portrait, covered by little indolent papules, most of which showed the effects of scratching. The eruption occurred only on the exposed parts, and I was assured that, although it never got quite well, it disappeared almost wholly in winter, and was always at its worst in hot weather. The lady was married and had a family. The distinction of the disease from any of the ordinary forms of acne will be recognised, first, in the fact that the hands were affected, and next in the absence of any limitation of the papules on the face to the ordinary acne positions. I may also point out the absence of pustules and comedones.

I have referred to this disease in page 106 of Archives, Vol. ii.

PLATE LV

SUMMER ACNE

Next the eruptions, which, although not wholly produced by summer are yet much aggravated by it, we have a form of pruriginous acne. This disease is well illustrated in one of the New Sydenham Society's portraits, and I have described it under the name of prurigo festivalis. It is especially common in young persons, and particularly in young women. The eruption is almost always worse in hot weather, and gets almost or quite well in winter. The liability to this form of summer acne in most cases ceases between the 20th and 30th year.

occurred in a lady of middle age who had been liable to it almost from girlhood. She was in excellent health, but her face, neck, and the backs of her hands were, as is shown in the portrait, covered by little indolent papules, most of which showed the effects of scratching. The eruption, according to the patient's wants, and I was assured that, although it was not cured, it disappeared almost wholly in winter, and was [illegible] worst in hot weather. The lady was married and had [illegible]. The distinction of the Disease from any of the ordinary forms of acne will be recognised, first, in the fact that the hands were affected, and next in the absence of any limitation of the papules on the face to the sebacious acne positions. I may also point out the absence of pustules and comedones.

I have referred to this disease at page 106 of Anæmias, Vol. ii.

West, Newman, chromo.

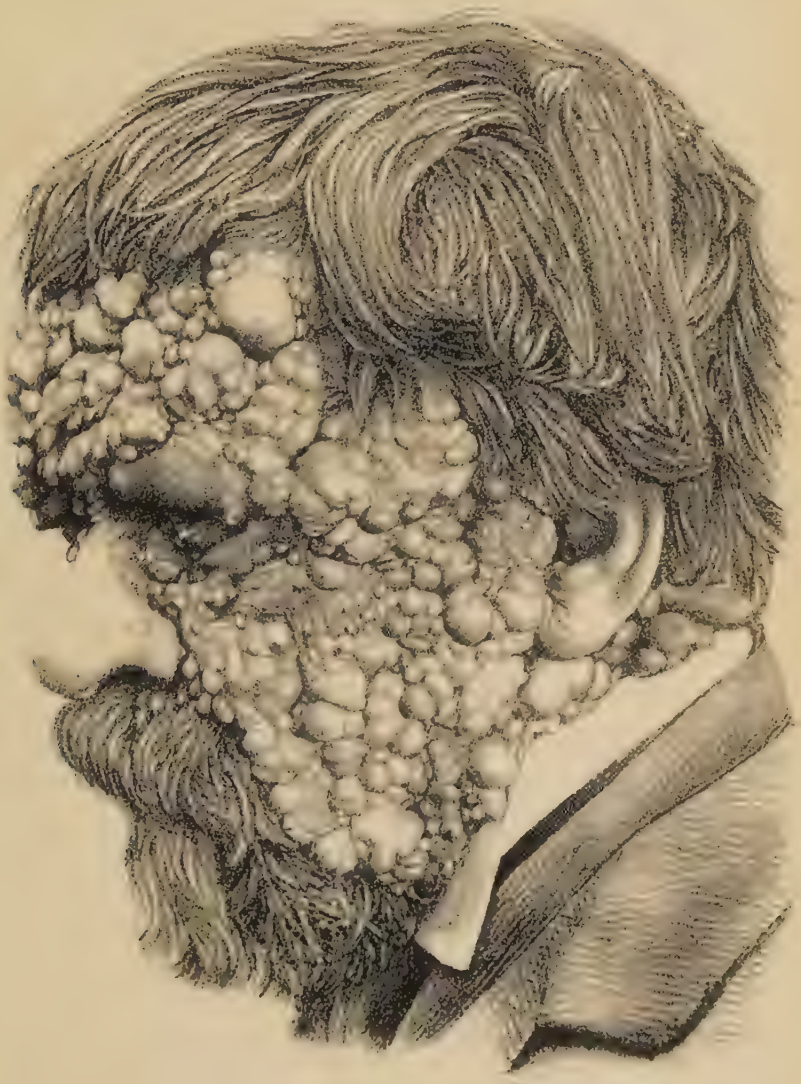
PLATE LXIV.

MOLLUSCUM FIBROSUM.

This portrait shows the present condition (1892) of a man who has for the last five and twenty years been under the observation of dermatologists in London. He now affords an example of most extensive molluscum changes. He is a man named Gray, and his portrait was published by myself in the New Sydenham Society's Atlas of Skin Diseases twenty years ago. It is Plate XVIII., and a full description of the man's condition is given in the catalogue.

A comparison of that portrait with the one which I now give is of great interest as showing the advance which the disease has made. At various times I have excised a great many of the growths from the face, more especially from the eyelids, where they were very inconvenient. It will be seen from the Plate that, although the molluscum growths are so numerous as to have become confluent over most of the exposed parts of the face, the ear and the nose are wholly exempt. The skin of the trunk and limbs is now affected in almost the same degree as the face, and it is of much interest to note that a certain number of tumours have formed inside the mouth on the palate, lips, &c. The tendency to the formation of these growths was first observed in early childhood, and they have been gradually increasing ever since. Although so severely disfigured the man still retains good health.

The case is a good example of what is usual in molluscum fibrosum, though it is perhaps one of the most advanced cases yet recorded.



West, Newman, lith.

THERAPEUTICS, &c.

No. XXV.—*Advantages of the Abortive treatment of Gonorrhœa.*

I ventured to write a few sentences in a former number of Archives in recommendation of the abortive treatment of gonorrhœa. My plan included the simultaneous use of purgatives, bromide of potassium, sandal-wood oil, and injections of chloride of zinc. These remedies, if all used together and no one forgotten, are, I believe, perfectly safe as an abortive plan in the most acute cases. The greater the severity of the case, the more desirable it is to employ vigorous measures. Begin with free purgation, and the rest is plain sailing. Since the paragraphs referred to were penned, I have come across an extract from a paper by M. Diday (1845) which has interested me. Diday held that copaiba acted more beneficially if combined with purgatives. He ordered an electuary of three drachms of the balsam, four and a half of cubebs, with forty-five grains of jalap. Of this one-half was to be taken in the morning and the rest in the evening, and five days is stated to be usually sufficient for a permanent cure.

It may be easily suspected that if the cure were not complete in the time, but few patients would be found willing to continue such a remedy. Since M. Diday's time we have got bromide of potassium, which is a very important adjuvant. We have also to a very large extent substituted oil of sandal-wood for copaiba. It is equally efficacious, far more agreeable to take, and much less prone to disagree. It does not produce eruptions.

In connection with the abortive treatment of gonorrhœa we have to consider the risk of complications. As to prevention of orchitis, cystitis, and stricture, I have no hesitation whatever in believing that the sooner the disease is cured the less is the risk of their occurrence. As regards the more constitutional affections, such as sclerotitis and iritis and gonorrhœal rheumatism, the question may possibly stand on different ground. I do not think, however, that it does so, and I believe that in order to prevent gonorrhœal rheumatism it is of first importance to cure the gonorrhœa. There is great reluctance on the part of some surgeons to try to stop a discharge after rheumatism has set in. Neither at this stage nor any other have I the slightest scruple. My theory of gonorrhœal eye-affections (I do not, of course, speak of true gonorrhœal ophthalmia due to direct inoculation) and of gonorrhœal rheumatism is that they occur almost exclusively in those who inherit gout, and that they are induced by the absorption of elements of contagion from the urethra. The sooner the latter is put into a healthy state the better; it will then cease to supply the materies which, circulating in the blood, causes the iritis or the arthritis. It may at the same time be quite true that the cure of the urethritis may not have much influence on the rheumatism, for when once a joint has inflamed, it itself becomes, under the same law, a source of contagion to others. The seed has been already sown, and other plants have been produced, and you cannot arrest the process by eradicating merely the original one.

No. XXVI.—*The use of Cod Liver Oil in Rheumatism.*

Cod liver oil has obtained such a definite reputation against tuberculous and scrofulous affections that we are apt to forget its virtues in other maladies. In the first instance it was employed against chronic rheumatism, and gained enthusiastic opinions. I have before me the original report in reference to this latter use by Dr. Bardsley, of Manchester, who in April, 1807, wrote that it had then for thirty years enjoyed a very high local reputation. It had been much used

in the Manchester Infirmary by Dr. Percival and by Dr. Bardsley himself. The latter reports that it is variable in its efficacy, often in the mild and more common forms not doing any appreciable good. He thought it most useful in chronic cases in elderly persons and in women debilitated by parturition. He thought that it seldom did good unless it fattened. His dose was half an ounce to an ounce and a half twice a day, and he found warm beer to be, with the labouring classes, the favourite vehicle. If benefit were obtained it ought to be continued for six or eight months. He asserts: "I have seen a few patients recover entirely by the exhibition of the oil who on their admission into the house were unable either to preserve the body in an erect position, or support its weight on the lower extremities."

The consumption of cod liver oil in the Manchester Infirmary from 1776 to 1807 had averaged fifty or sixty gallons annually. It now amounts to four hundred gallons.

The profusion with which new chemical remedies have been supplied to us of late years may, it is very possible, have led to the comparative neglect of old ones, and that, perhaps, not always to the advantage of our patients.

No. XXVII.—*Taraxacum with Nux Vomica in Liver Disease.*

I have recently seen a young man, now aged twenty-nine, concerning whom his father told me that I had "cured him of a drunkard's liver nineteen years ago." He is now in very tolerable health, though still suffering somewhat from dyspepsia. He has continued to take the medicine which I prescribed for him so long ago ever since, not quite continuously, but whenever his liver is out of order. He avers that nothing else which he has tried has so good an effect upon his health. When he was brought to me at the age of ten he was very much out of health, and the diagnosis of cirrhosis, or "drunkard's liver," had been confidently given by a distinguished provincial physician. His case had excited considerable interest before I saw him, and his parents had been assured that he was not likely to recover. With this history I was much interested in obtaining a sight

of my prescription which was reputed to have worked such wonders, and fully expected to find that it contained mercury. Such, however, was not the case. It consisted of five drops of tincture of nux vomica and half a drachm of taraxacum juice—to be taken three times a day. These doses were originally ordered when the boy was ten years of age, and for a year or two afterwards he continued them uninterruptedly with the most definite improvement in health. I never saw him excepting on the occasion of the first prescription. As he grew older he had somewhat increased the dose.

Taraxacum has been styled "vegetable mercury," and so far as its influence on the liver is concerned the two drugs appear to possess very similar powers. Its efficiency is, I believe, much increased by the combination of nux vomica. The chief point is, however, to give it in a sufficiently large dose. The doses in common use are much too small. A case of what may be called acute xanthalasma (see ARCHIVES, Vol. II.) in association with severe sick headaches, which I saw about two years ago, has apparently been greatly benefited by the use of taraxacum in full doses. We began in the first instance with small doses of mercury, but the vegetable drug was subsequently preferred. Under its long-continued use almost the whole of the xanthalasma patches have disappeared.

No. XXVIII.—*On the Influence of Season on Health.*

Although I am not able to appeal to any accurate collection of statistics, I yet feel but little doubt that the month of March is one in which those liable to gout and rheumatic gout are specially prone to suffer. My experience is most definite in reference to gouty affections of the eye. The same patients return to me, over and over again, in the early spring with attacks of recurrent iritis. I had a number of such cases during the last spring, and several of the patients told me that they were liable to annual attacks about that time of the year. In some the attack occurs with remarkable punctuality. In one of the most marked cases of recurring iritis which I ever saw, and in which I had the opportunity of observing the patient during a long series of

years, the attacks occurred repeatedly in the same week towards the end of February. It is not improbable that several conditions favour the development of such maladies in early spring. Chief probably amongst them is the occurrence of east wind and ungenial weather, which may act both directly upon the nervous system and indirectly upon the blood by diminishing the action of the skin. Then, too, we must remember that winter, as contrasted with summer, is to many people a time during which but little exercise is taken, whilst the consumption of food, and especially of animal food and stimulants, is increased rather than diminished. The cumulative results of this will probably be reaped in the spring months.

Amongst the conditions which are distinctly under the influence of weather and season, and liable to recur in the spring months, we must count irritability of the skin. The skin is liable to be dry, and probably the functions not only of the sudoriperous but of the sebaceous glands are much interfered with. Thus many patients complain during east winds and spring weather of a general pruriginous condition, which may be attended with more or less of lichenoid eruption. In this we have the prurigo hiemalis of Duhring, but there is also a prurigo æstivalis due to exposure to sun, and which in some instances may become a formidable malady. It is not, however, only in reference to diseases of the eye and skin that the influence of season may be traced, and I cannot but think that results of some value, in reference to the etiology of many obscure disorders of function, might accrue from carefully collected observations as to the influence of season on health. The resources of civilization have no doubt done much to equalize the seasons. Our food varies far less with time of year than it used to do; we are better clothed, and, above all, exempt from malaria. In all these directions our forefathers suffered much. Their estimation of the various risks is plaintively expressed by Jeremy Taylor in a passage which I shall trust to be excused for quoting:—

"Nature hath given us one harvest every year, but death hath two: and the spring and the autumn send throngs of men and women to charnel-houses. All the summer long

men are recovering from their evils of the spring, till the dog-days come, and then the Syrian star makes the summer deadly. The fruits of autumn are laid up for all the year's provision, and the man that gathers them eats and surfeits, and dies and needs them not, and himself is laid up for eternity; and he that escapes till the winter only stays for another opportunity, which the distempers of that quarter minister to him with great variety. Thus death reigns in all the portions of our time. The autumn with its fruits provides disorders for us, and the winter's cold turns them into sharp diseases, and the spring brings flowers to strew our hearse, and the summer gives green turf and brambles to bind upon our graves. Calentures and surfeit, cold and agues, are the four quarters of the year, and all minister to death."

MISCELLANEOUS.

No. LXV.—*Dwarfing of the Radius after Detachment of the Epiphysis in Childhood.*

A very interesting example of dwarfing of the radius after injury to its carpal epiphysis came under my notice in the wrist of a medical friend. During a consultation I noticed that the ulna of his right wrist projected greatly, and, having asked permission to examine it, I found the ulna at least three-quarters of an inch longer than the radius. There was not so much obliquity as is usual in these cases. The wrist was simply placed at the distance named above the end of the ulna, the lower part of the forearm and hand being nearly straight. I was told that the condition had resulted from an accident which occurred at the age of four.

No. LXVI.—*Senile Arteries of very large size with good health—Temporals not enlarged.*

In the case of Mr. J. B——, æt. 69, a short, very florid and stout man, who had enjoyed excellent health, I found very large arteries. His radials were easily felt at the back of thumb, and his radio-palmaris was in both hands as big as an ordinary radial. His tibials were also very large, but his temporals were not especially visible.

I asked him if any one had ever noticed any peculiarity in his pulse, and he said "Yes; eight years ago Mr. Lund, of Manchester, before whom I went for insurance, looked very grave, and said that my pulse was very slow. He afterwards told me not to think anything of what he had told me, and assured me that I was good for twenty years."

I found no murmur at his heart, but it was probably large. His pulse was slow, and exceedingly strong and full.

The case is of interest because the condition had attracted attention so long as eight years ago, yet no inconvenience had accrued.

Some risks of spreading thrombosis and its attendant gangrene, and some of rupture of cerebral vessels, probably attend these cases of senile enlargement of arteries. They are, however, only remote. I cannot in a general way associate these large arteries with any special cause, nor make them the basis of any special prognosis. They occur solely in association with advancing age, and almost solely in the male sex.

No. LXVII.—*Fatal Gangrenous Stomatitis in Adults.*

In the recent number of the St. Bartholomew's Hospital Reports (1891), two cases are recorded of conditions in adults somewhat resembling cancrum oris in children. In both, ulcerative stomatitis resulted in dropping out of teeth and alveolar necrosis, and finally gangrene of the cheek. Both cases ended fatally, the one after more than four months, the other after about one month. Both had began insidiously as sore lips or sore mouth, and in both the last stage of gangrenous extension was short. Both the patients were men, one of them forty-seven and the other thirty-one. Mr. E. W. G. Masterman, who records these cases from the practice of Mr. Morrant Baker and Mr. Marsh, states that no special cause for the disease could be discovered in either. One of the men was a tea-taster and the other a packing-case maker. Mr. Masterman informs us that tea-tasters of Indian tea are apt to get sore lips, and in some cases the condition advances to stomatitis with necrosis of alveolus, and ends in death. Both of the cases differed from cancrum oris as seen in children, in the fact that the alveolus was affected very early and the soft parts became gangrenous only in the last stage. The reverse of this is, as is well known, the rule in children.

No. LXVIII.—*Subcutaneous Indurations about the fingers.*

An old gentleman of seventy has a solid, flattened, oval,

firm, fleshy tumour over the knuckle of his left forefinger. It has been present six or eight years. I do not know that I ever examined any growth quite like it. It is adherent to the skin, and quite loose upon the deeper structures. It does not, however, in the least, infiltrate the skin, and there is not the slightest trace of redness or inflammatory action about it. It is a flattened cake-like mass, an inch and a half in length and an inch broad, and probably in the middle about a quarter of an inch in thickness. It covers the knuckle joint, and extends downwards over the metacarpal bone of the index finger. There is nothing of the nature of a bursa about it, nor does there appear any reason to connect it with gout.

My remark above that I have not seen other cases exactly like this, must be held to apply to its size and its non-infiltration of the skin. Indurations about the fingers, attached to the skin and infiltrating it, are of course not very uncommon, and especially, I think, in the subjects of gout. They seldom, however, attain the size of that described, and are firmly incorporated with the deep layers of the skin.

No. LXIX. — *The trunk of the Third Nerve injured by a shot—Description of the subjective symptoms at the time of accident.*

An instance of complete paralysis of the third nerve from a very singular and exceptional cause came under my notice in the case of a gentleman from Yorkshire, named T——. He had been struck, whilst out shooting, by a single pellet of ordinary partridge-shot, which had entered his upper eyelid on the right side, a little above the inner canthus. He was sent to me by Dr. Adams, of Dingwall, with the statement that the symptoms from the first had been those of complete paralysis of the third nerve. The lid had drooped, the pupil was widely dilated, and movements upwards, downwards, and inwards were lost. The wound had been probed but the shot could not be felt.

In the first instance there was much ecchymosis of the eyelids. Twelve weeks had elapsed between the date of the accident and Mr. T——'s visit to me, and during the latter

part of this period there had been gradual symptoms of improvement. The first gain had been the ability to lift the upper lid, and next a diminution in the size of the pupil. When I saw him the various muscles appeared to have regained their power in an almost equal degree. He still had divergent strabismus, and the pupil was still twice as large as the other. The pupil, however, acted freely on exposure to light, and he could with effort accommodate sufficiently to read ordinary print. He could use all the external muscles supplied by the injured nerve, but none of them quite perfectly.

I inquired as to the symptoms which had attended the accident. Mr. T——, an intelligent and observant man, said that he had no idea at the time that he had been shot. He felt as if some one had struck him on the forehead with a brick, and almost immediately afterwards he fell backwards. He then got up again and fell backwards again. After this he recovered, but felt very giddy and was sick. He was assisted home and put to bed, but during the next two days he continued to be very sick.

The symptoms described were possibly consequent on the shot-pellet having entered his brain, but they may perhaps have been due only to the sudden disturbance of vision, diplopia, &c. In the course of about a week he was quite himself again, with the exception of the third-nerve paralysis.

No. LXX.—*On the importance of keeping local Registers of Disease.*

Sir George Mackenzie (who travelled in Iceland with Dr. Holland) writes in his journal:—"We were gratified with the sight of Mr. Hjaltalin's parish register, in which is an entry, made annually, of the state of each family in the parish. Under the head of each family were entered, in separate columns, the condition of each individual; their age, whether confirmed or not, whether able to read, general conduct, abilities, &c.; also a list of the books belonging to each family." Mr. Hjaltalin was, of course, the village pastor.

The conditions of the village clergyman and the village doctor, as regards the demands upon their time, are of course

very different. It is, however, I cannot but think, much to be desired that, amongst those of us who are placed under favourable circumstances, more effort in the direction of an attempt at keeping local registers should be made. Mere death-lists, if accurately and fully kept, would become, in the course of years, of great value. I mean lists which should assign and classify the causes of deaths, aiming at a degree of accuracy and detail much greater than that attained by the registrar. Yet more useful, though, perhaps, involving much more labour, would be chronicles of the prevalence of non-fatal maladies—a journal of daily practice—with reference to season, weather, conditions of residence, family tendencies, and the like. There are plenty of young surgeons, well-trained observers, zealous for the development of knowledge, and not unambitious of scientific reputation, who might perhaps find in professional work of this kind efficient counter-attractions to lawn-tennis, &c. Unfortunately, it is too much the habit to think nothing worth investigation but what is rare, whereas it is really in common things that our knowledge is most defective. We need in medicine a reform much like that which Wordsworth effected in poetry. We need to come down from our stilts, and to be willing to take interest in subjects which, because they bring to us our daily duties, but too often appear common and insignificant.

I have met many clergymen who, in the quiet of rural parsonages, had kept notes of rainfall and wind; and others who knew for twenty years back the days when the first swallow had been seen, and the first cuckoo heard, but I have seldom found a medical man who had anything more accurate than his memory to trust to as to when he had seen cases of diphtheria, croup, or mumps. A village surgeon might do well to take Gilbert White * as his model, but should keep for the most part to professional topics.

* "He Boswellised the Birds; he took down the familiar conversation of Nature," was the comment on White of a medical friend in whose company I made a pilgrimage to Selborne. Perhaps I shall be told that White himself did not keep to his own profession. Well, for that he is to be more than pardoned, but the case is very different with us.

No. LXXI.—*Horace Walpole's experience in reference to cold-catching.*

"Sometimes a walk in the grounds would intervene, on which occasions he would go out in his slippers through a thick dew; and he never wore a hat. He said that on his first visit to Paris he was ashamed of his effeminacy, when he saw every meagre Frenchman whom even he could have thrown down with a breath, walking without a hat, which he could not do, without a certainty of that disease which the Germans say is endemial in England, and is termed by the natives le catch-cold. The first trial cost him a slight fever, but he got over it, and never caught cold afterwards; draughts of air, damp rooms, windows open at the back, all situations were alike to him in this respect. He would even show some little offence at any solicitude expressed by his guests on such an occasion, as an idea arising from a seeming tenderness of his frame; and would say, with a half-smile of good-humoured crossness, 'My back is the same with my face, and my neck is like my nose.' His iced water he not only regarded as a preservative from such an accident, but he would sometimes observe that he thought his stomach and bowels would last longer than his bones; such conscious vigour and strength in those parts did he feel from the use of that beverage."

It is not improbable that there is some exaggeration and much inexactitude in the above statements. At any rate of this I am sure, that, if correct, Walpole's experience was very different from that of most people. Many can, it may be admitted, easily acquire immunity as regards going out hatless. Exposure of the hairy head to the open air is by no means one of the commonest causes of cold-catching, and the wearing of a hat may be held to be, for the most part, a matter of habit. I know many persons who care nothing about their hats, and will go without one even in a cold wind, but who yet dare not enter a damp, unused room or sit five minutes in a draught. I never heard of any one of catarrhal susceptibility who had by any training whatever acquired the ability to sit, without risk, in a draught. Nor

can many in the least help themselves in reference to damp feet. Above all, a damp room, one which has not been used for a week or two, is sure to give a catarrhal subject a cold. It is interesting that Erasmus noted this and thought English rooms (that is, rooms without stoves) especially dangerous. Water-drinking (even of iced water) is certainly no preventive of catarrh ; indeed it may be suspected that abstainers suffer more than others. The catarrhal susceptibility is at its lowest when the blood is well charged with alcohol. There is an important anecdote told of the elder Darwin (of Leicester) which enforces this text.

If I were asked as to the best means of reducing catarrhal liabilities, I should say, clothe warmly, live in a dry locality and in a dry house, use cold bathing, and take food and stimulants as liberally as may seem judicious. I would add, on no account attempt to harden yourself by getting wet or sitting in draughts.

The real truth about Horace Walpole is probably that he never was, in any strong sense of the words, a catarrhal subject, but that he had been bred up in the notion that it is impossible to go into the open air without a hat. He easily acquired by practice the ability to do this, and as regards the other susceptibilities simply he never had them.

No. LXXII.—*A typical and severe case of Raynaud's phenomena—Maternal grief as a cause—Approach to the conditions of diffuse Morphœa.*

I saw, with Dr. Clarke of Clapton, a very remarkable example of Raynaud's disease in which some of the phenomena resembled diffuse morphœa. The patient was a lady of thirty-nine, who, although never strong, had in the earlier part of her life enjoyed fair health, and manifested no peculiarity of circulation. In childhood she had suffered from chilblains, but not severely. Her father, whom I saw at the time of my visit, was a remarkably vigorous man, who said that he did not know what it was to have cold hands or feet. The disease in our patient appeared to have commenced very definitely about four years ago, and to have been

due to severe emotional disturbance. Just before her hands began to die, Mrs. G—— had lost her only child. He was a promising boy of six, and died of diphtheria after only a few days' illness. Mrs. G—— took her loss very much to heart, and for some time afterwards spent long periods every day at the cemetery. About this time she began to suffer very much from cold hands, and her fingers would die. Her feet were affected in a similar manner, but much less severely. By degrees this susceptiblity increased, being always worst in cold weather, but never wholly absent.

I saw Mrs G—— on August 20, 1892, during very hot weather. She was confined to her bed, and in a state of extreme suffering from gangrenous ulceration of the tips of several of her fingers. Her fingers were stiff, slightly swollen, pale and tallowy. Several of them were livid and slightly ulcerated at their tips, and others showed scars consequent on former ulceration. The skin on the backs of the hands could not be pinched, and the general conditions might be described as board-like. They differed, however, somewhat from those met with in well-characterised scleriasis, in that there was no demonstrable atrophy of the skin, the tightness and high-bound state being much less marked. The changes were also restricted to the hands, and almost to the digits. There was no appreciable change in the skin of the fore-arms. In the feet there was no evident hardening of the skin, but the toes were distinctly dusky at their tips. There was an inflamed sore over one malleolus, which had been caused by a slight bruise. The state of Mrs. G——'s face was very peculiar. The skin was not actually board-like, as in morphœa, nor did it show any definite stigmata. It was, nowever, somewhat tight, and was covered with desquamating erythematous patches. She could close her eyelids and lips easily, but said that they felt more or less stiff. There was no change in the skin of the neck or chest. Mrs. G—— was thin, and had emaciated considerably of late. The erythematous condition of her face had been observed only during the last six months. Very distinct paroxysmal attacks were described, and they would occur often two or three times in the day. Mrs. G—— said that she knew when an attack was

coming on by a peculiar feeling of aching and discomfort in the limbs. Then her face would flush and her fingers become white. After the stage of pallor had lasted a short time, it was followed by one of duskiness, during which they became quite livid. Her nurse, who was an observant woman, told me that the smallest quantity of stimulants, or even a cup of hot beef-tea, would make the face flush up in the most extraordinary manner. Milk did not do it.

In contrasting this case with one of diffuse scleriasis we must chiefly take note of its history and of its paroxysmal character. It must be observed that although the local conditions present similarities, they are by no means quite identical. Thus, neither in the face nor in the fingers was the condition of atrophic thinning and stiffness, often so characteristic in scleriasis, at all approached. The limitation of the changes to the hands and feet must also be kept in mind.

No. LXXIII.—*Hæmoptysis in the Aged.*

Petit, the great French surgeon, at the age of seventy-seven (on April 17, 1750) was seized with spitting of blood. He died on the 20th. I have not been able to find any details as to his illness, excepting the appended quotation from the "Eloge" pronounced by M. Louis, which Mr. Bailey, the Librarian at the College of Surgeons, has been good enough to obtain for me :—

"Il eut dans l'espace de six mois deux ou trois oppressions de poitrine que quelques saignées avient calmées : il lui en resta une difficulté habituelle de respirer qui augmentait au moindre exercice un peu violent. Il fut attaqué d'un crachement de sang considérable, le 17 du mois dernier (Avril, 1750) et il mourut le 20, au commencement de sa soixante et dix-septième année."

This fact is not without its interest in reference to what Sir Andrew Clark has recently written as to hæmoptysis in the aged (see Transactions of Medical Society, 1891).

The occasional occurrence of profuse, or even fatal, epistaxis in the aged has of course been for long well known. In such cases the surgeon is occasionally consulted, and plugging of

the nostrils may sometimes be thought needful. So far as my observation has gone, these attacks do not usually occur in persons known to be the subjects of special arterial disease, although, of course, in the senile this can never be excluded. They appear to prove the possibility of local congestions of mucous membranes in persons apparently in good health, which relieve themselves by hæmorrhage, which latter may be profuse and almost uncontrollable. Sir Andrew Clark insists upon the absence of obvious arterial disease, especially of capillary fibrosis.

Amongst those who have confirmed Clark's observation is a Malta physician, Dr. Busutil, who has recorded three cases, one of them fatal, in the *Rèvista Medica*.

The treatment recommended by Clark is by saline purgatives and iodide of potassium. To these I will venture to add, as a means to the arrest of the hæmorrhage, the use of the continuous pediluvium, the temperature of which should be well kept up. I have never once plugged the nostrils for epistaxis since I knew of the efficiency of this simple measure.

In connection with these cases of severe hæmorrhage from mucous surfaces we may suitably consider certain others in which the blood is discharged from the surface of a morbid growth. In most instances of hæmorrhage from cancer we may reasonably suspect that some artery of greater or less size has been opened in the course of extending ulceration. I do not, however, think that this can be held to be the cause in all, for the attacks of bleeding are not single ones but are recurrent, and sometimes persistent for much longer periods than would probably be the case if an artery were opened. My impression is that cases of the latter group are usually of the nature of surface hæmorrhages, and very similar to those which occur from the nose or lungs. In support of this view it may be noted that often the malignant disease in hæmorrhagic cases is attended by growth rather than ulceration. The worst examples of recurrent bleeding from cancerous growths which I have had to do with have been in cases of cancerous disease of the lower bowel, attended by the production of polypoid masses. I attended many years ago an elderly clergyman who had come up to town in very tolerable health

on a visit to friends. He had in his rectum a large polypoid mass of cancerous growth which gave him but little trouble. Suddenly he began to suffer from bleeding, and this was so profuse and so frequently recurrent that in the course of ten days he was reduced to a most alarming condition. After a fortnight in bed under the use of ergot and other measures the bleeding ceased. He regained his health, and lived in tolerable comfort two years longer. A precisely similar case has been under my care quite recently, and has for the present been cured by similar means.*

No. LXXIV.—*A very remarkable Example of Repeated Attacks of Hæmorrhage into the Tissues of one Thigh.*

A young gentleman who was brought to me from Belfast presented a most remarkable example of recurring liability to hæmorrhage into the intermuscular spaces of his lower limbs. He had had what he called repeated attacks of rupture of veins, in consequence of which his legs had been so much damaged that he was now obliged to walk with crutches, and in consequence of retraction of his heels could only bring his toes to the ground. Both lower extremities were very much shrunken, the atrophy involving almost all the muscles alike. There was no absolute paralysis of any one set of muscles. In the left leg common sensation appeared to be very much reduced, and the knee-jump was quite lost. Yet he was extremely sensitive to tickling of the sole, which, indeed, appeared almost to give him pain. He himself confidently attributed this numbness to the attacks of hæmorrhage into the limb from which he had suffered. It had followed on the last of a series of attacks of hæmorrhage, which had been a very severe one, and occurred about eight months ago. In that he said the limb had been enormously swollen, and he had been confined to bed for ten weeks on account of it. During most of this time, spirit and opiate lotions had been

* The reader may find an interesting case of fatal non-tubercular hæmoptysis in the last volume of the Clinical Society's Transactions, by Dr. F. Hawkins, page 237.

applied. When he left his bed the joints of both knee and ankle were somewhat stiffened, and his heel drawn up. It was difficult to estimate the degree in which sensation was defective. He always perceived the prick of a pin, though not acutely, and he could generally tell when touched by the finger. He allowed, however, tolerably firm scratching with a pin's head without being able to recognize it. The numbness was greatest on the dorsum of the foot and over the toes, and shaded off gradually on passing up the extremity. Above the knee he could feel as well on one side as the other. In the right limb the patella was ankylosed to the femur, but there was some motion between the tibia and femur. The joint had not the slightest appearance of a scrofulous affection, there being scarcely any thickening of any part, and no scars of abscesses. The disease in it had occurred many years ago, and had lasted for long. So far as the history could be obtained, it seemed probable that it had been of a hæmorrhagic nature. I was told that incisions had been made into the swelling, but that no matter had ever been discharged. It occurred to me as possible that the anæsthesia of his left limb might be due to defect of circulation, and that his attack might have been one attended by plugging of the femoral artery. I could, however, easily find his posterior tibial on that side, and its beats were not more feeble than that of the other. Both his feet were cold, and the right was clammy. My first thought on seeing this young man's legs and lower extremities was that he was the subject of infantile paralysis. But the history was conclusive against such a diagnosis, and so also were the facts that the muscular weakness was general, no single set of muscles being affected, and that there was some degree of anæsthesia.

I must now attempt to give some history of the case as I obtained it from the patient himself and his father. It appeared that there was no known history of the hæmorrhagic diathesis in the family. He was one of a family of seven, four sisters and two brothers; and none of the others had suffered from hæmorrhages.

There was believed to be a strong tendency to gout on his mother's side. Most of his mother's relatives had gone out to

America, and not much was known as to the details of their health. This lad had been supposed to be a bleeder all his life. When quite a child, if he had a cut, or bit his tongue, very troublesome bleeding had always occurred. His father said that the tongue after being bitten had sometimes continued to ooze for three or four days, and that he had often had to consult a surgeon for the arrest of the hæmorrhage. He described the bleeding as a continued oozing, but said that it had never gone so far as to make them anxious about the child's life. During boyhood there had been very troublesome attacks of nose-bleeding, but these had ceased since the liability to hæmorrhages into the limbs had shown itself.

Mr. McA—— remained in London about a month, during which we endeavoured to improve the condition of his muscles by massage and electricity. The re-action of the muscles was imperfect. During our treatment a slight attack of general ecchymosis occurred, attributable probably to the rubbing. There was some slight swelling and a general appearance of bruising, but no signs of any large vessels having given way. He was able at this time to get about with his crutches, and enjoyed fairly good health. He never suffered from headache, and the only complaint which he made indicating inequality of circulation concerned a liability to flush on his face and head if he exerted himself, and to break out in perspiration on those parts. His pulse was usually sharp, but compressible, and he continued very pale. In general aspect, in liability to flush, and in the character of his pulse, this lad much resembled my patient whose case is recorded at p. 13, Vol. III., and who had suffered from hæmorrhages into the eye.

The following is an extract from a letter from Dr. Dunlop, of Holywood, who sent the patient to me :—

"The last attack of hæmorrhagic infiltration took place early in January of the present year (1891), and when I saw him the whole thigh was involved and swollen to an enormous extent, the pressure giving him great pain, and the loss of blood blanching him very much. The pain was so great that I had to give him morphia to a considerable extent. The lead and spirit lotion after a considerable time relieved him, and ultimately absorbed the blood. So little will cause injury and extravasation, that I was afraid to use either massage or much friction."

Dr. Dunlop has been good enough to inform me recently (Sept., 1892) that our patient's condition has much improved during the past eighteen months. He has not had any return of hæmorrhage.

No. LXXV.—*Liability to temporary total blindness on assuming the erect position.*

A lady who had consulted me about arthritis, told me incidentally that she was "liable to lose her sight." On inquiring what she meant, she said that any sudden movement, but especially suddenly rising to the erect position, would place her for a short time in total darkness. She thought that the darkness lasted usually "as long perhaps as you could count thirty." On two occasions, when holding a candle, she should, she said, have set fire to objects near her had not her friends prevented it. She was accustomed to carve at table, and several times on rising to do so had been obliged to wait for a minute or so because in total darkness. Her sight always returned in a very short time, and without any headache or other inconveniences. She considered that her sight was good, but for a week past she had desisted from reading because it made her head ache. I found on trial that her vision was not so good as she imagined. She could, however, see $\frac{2}{5}\frac{0}{0}$, and could read No. 4. On using the ophthalmoscope I found both discs involved in neuritis, their edges blurred, and the trunks of the vessels concealed. There were no white dots or streaks, and my son and I, who examined her together, agreed that there was no evidence of albuminuria. Subsequently, however, having obtained a specimen of the urine, we found that it was of very low specific gravity (1005), and loaded with albumen.

I record this portion of a most interesting case solely in reference to the symptom described. It is one not often met with, and I have never known a patient describe such definite and frequent attacks in connection with change of posture. The ophthalmoscope fully explained it. No doubt the temporary failure of sight was due to the inability of a weak heart to overcome the local impediments to arterial circulation caused by neuritis.

No. LXXVI.—*Senile Hypertrophy of Arteries—No evidence of Cardiac or Visceral Disease.*

I mentioned in the last number of ARCHIVES, p. 257, my belief that there are cases in which the arteries undergo hypertrophy independently of disease of heart or kidneys. The condition is, I think, usually one of senility, and not infrequently leads to inflammatory thrombosis and gangrene. My note-books contain a good many examples of this condition.

Mr. P——, aged 80, has during the last few years several times consulted me on account of eczema. He is in perfect health, and has been accustomed all his life to take a great deal of exercise. He has lived most temperately. His father died at 84, and his mother at 65. His heart-beat is quiet and regular, and he never suffers from palpitation. His arteries are remarkably large. Thus his pulse at the wrist can be very easily counted by the eye, and is easily felt between the metacarpal bones or in the superficialis volæ. His temporals are tortuous and large, but not increased in ratio with the radials. The femorals and popliteals are also large, but I could not detect either the anterior or posterior tibials. He has had some symptoms suggestive of impediment of the circulation in his legs, and it is very possible that some degree of occlusion exists. He has had several attacks of sudden pain in the legs. Twice this pain seized him while going upstairs. It was located just behind the knee, and was so severe that he would have fallen if he had not caught the banister. He remembers that six years ago he had a similar attack of pain in the right leg, and says that he has occasional shoots of pain which make him feel as if he would fall. Mr. P—— is a tall, rather thin man.

No. LXXVII.—*Tracheotomy and Intubation in the treatment of Diphtheria.*

It is exceedingly difficult to explain the differences in the ratio of success from tracheotomy in croup at different hospitals and in the hands of different surgeons. At the Highgate Infirmary, as noted in the last number of ARCHIVES, p. 21, Dr. Gayton was inclined to attribute their recent successes to

the practice of early and frequent removal of the tube, in order to permit of the extraction of membranes, and to the spraying of the wound with a mercurial solution. At the Heidelberg Hospital for Children Dr. v. Beck told me that their proportion of recoveries was 50 per cent. whilst neither of these precautions was in use. Great attention was however paid to the removal of membrane, and the employment of a suction bottle with a small rubber tube attached, which can be passed down the canula, very possibly in his hands serves the purpose which others attain by frequent removals of the latter. As has been so well and persistently urged by Mr. R. W. Parker, the removal of membranes, not only at the time of the operation, but as often as they may be re-formed, is the key-stone of the procedure. Without it tracheotomy is little more than a farce. To put trust in the canula as if the obstruction existed solely in the larynx, and all that was necessary is to secure an access to the trachea below it, is to lean on the weakest of reeds. It would be safer to dismiss the canula altogether, and to regard the operation simply as a means of gaining access to the trachea for the purpose of repeated removal of membrane.

At every hospital which I visited in Austria or in Germany I made inquiry as to the prevalence or otherwise of diphtheria, and as to the degree of success which attended its treatment by operation. At Munich, as I have already noted, intubation has wholly superseded tracheotomy ; the same is the case at Budapest, where a total of three or four hundred cases treated by intubation with great success was mentioned to me. The more ardent advocates of intubation use it in the first instance in all cases, and resort to operation only when the child cannot bear the irritation of the tube ; others use it only in selected cases. It has the obvious advantage that it may be adopted earlier in the case than tracheotomy would be held justifiable, but all will agree that it cannot be recommended as being on the whole easier of accomplishment in inexperienced hands than the latter. My inquiries in this matter procured me incidentally an interesting item of information respecting climatic and hereditary tendencies. Dr. Fiertz, who, practising in Zurich, has there had consider-

able experience in tracheotomy operations, assured me that it was definitely a more difficult procedure in native Swiss children than in strangers, on account of the all but universal prevalence in the former of enlargement of the thyroid. He said that this was always encountered in the operation, although there might be no evidence of bronchocele before commencing.

No. LXXVIII.—*International and Topographical Statistics of Prevalence of Disease.*

The collection of international and even of topographical statistics of disease appears to me well worthy of more attention than it has received. I will try to illustrate what I mean by referring to two or three subjects which my readers will find mentioned in different parts of the present number of ARCHIVES.

If, as many observers think, lupus is a very common disease in Bohemia and a rare one in Bavaria, whence comes the difference? First we have to ascertain the nature of the facts which lead to this conclusion and to estimate their degree and extent. This done it is obvious that a number of most interesting questions would arise in the course of our search for explanation. If it should come out that after all the prevalence of lupus is not in ratio with that of other tubercular affections, a not unimportant item of evidence as to its nature would be obtained.

Dr. Fiertz at Zurich, and Dr. Beckh at Nuremberg, both assure me that prurigo and pruriginous affections in general are extremely rare in their departments of practice. At Vienna they are reputed to be extremely common. Questions as to race, diet, clothing, cleanliness, etc., etc., at once suggest themselves in reference to the explanation of such a difference.

That ringworm is far less common in Switzerland, Austria, and Germany than it is in France and in England appears to be beyond doubt. We want, however, accurate statistics on this point, and for those of us who believe that alopecia areata is for the most part a sequel of ringworm, it is of almost crucial importance to ascertain whether the ratio of prevalence of the two is usually the same.

DOCTRINAL PATHOLOGY.

Dr. Hirsch in his philosophical work on geographical pathology comes much nearer to a correct definition of erysipelas than most of our modern clinical writers. He at any rate avoids the blunder of considering it a specific fever. He writes: "I may define erysipelas to be an infective inflammation, disease of the skin, or of one of the mucous membranes near to the external surface of the body (mouth, throat, vagina, &c.), which in all probability proceeds invariably from a solution of continuity, or wound, and is characterised by its rapid extension over the surface, and by *the infective fever which accompanies the local process.*" Here we have a clear recognition of the fundamental fact that the fever is produced by the local inflammation, and not the reverse. The two weak points in the definition are the attaching undue importance to injury as an exciting cause, and the suggested exclusion of the mucous tracts where concealed from view. There is, I would suggest, not the slightest improbability in the belief that inflammation of the erysipelatous type may affect any mucous, or even serous, membrane, and may indeed originate in them. It is only because the skin and certain parts of the mucous tracts are exposed to view, and we therefore see erysipelas only on them, that we have got the idea that it is a disease to which they specially, or even exclusively, are liable.

I was once asked to see a gentleman upon whom another surgeon had operated for fistula ten days before, and who was believed to be about to die. I found him with his legs drawn up in bed, the whole abdomen extremely tender, and with high and varying temperatures. The operation wound was not in a healthy condition, but there was nothing resembling

erysipelas about it. We agreed to treat the case as one of peritonitis, and gave mercury and opium. Four or five days later erysipelas appeared about the wound and spread over the thighs and scrotum. About the same time the abdominal symptoms disappeared, and the treatment being changed for full doses of steel and quinine the patient rapidly recovered. My final interpretation of the case was that there had probably been present an erysipelatous inflammation of the bowels (whether of their mucous or serous coat might be hard to say), and that this had travelled downwards and finally appeared externally. No doubt it had originated from the wound, and the exceptional feature in the case is that it did not in an early stage attack the skin. It is, I think, not improbable that many deaths after abdominal operations are really due to internal erysipelas. Of this puerperal fever (peritonitis) is of course our best example.

Dr. Hirsch's limitation of the term erysipelas in the definition just quoted to inflammations beginning from wounds is, I conceive, a grave error. It leads at once to the exclusion of a large group of inflammations really erysipelatous in their nature. There is, I think, abundant proof that medical or idiopathic, and surgical or traumatic, erysipelas are the same malady and attended by the same microbe. That they are clinically transmutable, and that the one may originate the other, I cannot doubt. We have besides a large intermediate group, that in which inflammations of erysipelatoid type attack structures already the seat of disease but not recently injured. This we see occasionally around old ulcers, patches of eczema on lupus, but above all in cases of elephantiasis. Respecting the latter, Dr. Hirsch allows names to mislead his judgment. He writes respecting the so-called "wildfire of the legs," supposed to be common in Brazil, and counted as erysipelas: "The disease in these cases is clearly not erysipelas, but elephantine dermatitis (pachydermia)." The true interpretation of the phenomena of elephantiasis is, I believe, this. The disease in nine cases out of ten begins by an attack of erysipelas, due to contusion or some slight injury; the lymphangitis, which is the essential element of

all erysipelatous inflammation, leaves behind it chronic œdema, and it leaves also quiescent germs by which a like process is at intervals repeated over and over again. The elephantiasis condition results in fact from recurring attacks of erysipelas in a depending part prone to persisting œdema. The disease which I have been bold enough to name eczema-erysipelas has, I feel, increasingly a real clinical being. As a matter of mere conjecture, but with some probability, it may be supposed that in these affections the microbe of erysipelas meets the contagious material of eczema, and they mutually restrain and modify the action of each other. We have several varieties of eczema-erysipelas. One of the most definite—one of which I could produce twenty examples all exactly alike—is an affection to which adults past middle age are chiefly liable, and which attacks the face and causes the eyelids to swell just as in idiopathic erysipelas. It differs from the latter, however, in that it does not on disappearance leave the skin sound, but in a state of chronic eczema. Repeated attacks at longer or shorter intervals occur, and in many instances, after some years liability, the hands are affected also. The liability appears to be well-nigh irremediable. I have at present two ladies under observation, in both of whom I have watched the phenomena of the malady for several years without being able permanently to prevent them.

Are there any catarrhal forms of dermatitis? The answer to this question depends, of course, upon the definition which we decide to permit to the word catarrhal. For myself everything is catarrhal which is evoked by influences similar in kind to those which cause ordinary cold-catching, or catarrhal inflammation of the mucous membrane of the nose and throat. Cold in the head is the type of what is catarrhal, and nothing should come under that designation which does not, as regards its cause, course, and terminations, conform to parallel laws. The cause of a catarrhal inflammation is usually, perhaps always, the influence of cold and damp upon some part of the body's surface at greater or less distance from the part affected. The first effect is disturbed functions, an arrest, or more frequently a great increase, in the normal secretions. All catarrhal inflammations run their course and

tend to spontaneous termination, but all are very liable, after intervals more or less definite, to return. Some individuals are far more liable to catarrhal inflammations, and the proneness varies at different periods of life.

Keeping in mind the above statements we are in position to proceed, with some hope of success, to find an answer to the question proposed. If, on the other hand, we are content to regard as catarrhal everything which is chronic and presents a weeping surface, our terms will lack precision and our quest will end in confusion. Do such influences as commonly cause a cold in the head ever produce instead a transitory and subacute form of dermatitis? Are there individuals who instead of getting a running cold after exposure to damp get a sharp attack of inflammation of skin, and in whom this peculiar or erratic development of phenomena is often repeated?

The essential features of catarrhal inflammations (apart from their cause) are tendency to spontaneous recovery, completeness of disappearance, and proneness to recur after an interval.

Amongst the essential characters of eczematous inflammations is the proneness to persist indefinitely and become aggravated if not cured by art. Herpetic inflammations disappear spontaneously and are uninfluenced by art, but they very seldom recur, if we except those forms which are symptomatic, and which are often attendant on catarrh. Erysipelatous inflammations always disappear after a time, but their duration is indefinite, and they may be much influenced by art. They are very liable to recur after periods of health, and more especially when, as in the case of elephantoid hypertrophy and eczema-erysipelas, the tissues have never returned to a state of perfect integrity.

I have often wondered that no one has attempted to give a more systematic account of that very important subjective symptom, pain, than has as yet been done. Mr. Hilton's work, although having the word pain as part of its title, has but very fragmentary references to it as a symptom. What

we seem to need is a descriptive classification of the different kinds of pain, with reference to the various structures affected, and its special causes so far as they can be estimated. It may be alleged that this is an almost impossible task, since those who suffer pain are often far from skilful in their descriptions of it, or even in their attempts to locate it. Much, however, might I feel sure be effected by care and patience. We must select intelligent patients, and begin with well characterized and definite cases. The descriptions should, when possible, be obtained during the existence of pain, and not merely from memory. Unfortunately in many instances it may happen to the medical observer to have an opportunity of describing his own sensations. To give an instance of a typical kind of pain, I would mention that which attends the form of neuritis which produces herpes zoster. This should be discriminated from the pain, often yet more severe and frequently long persistent, which follows herpes. In the fact that herpetic neuritis may by disorganising a nerve cause it to become the seat of distressing pain for years afterwards, we have possibly a clue to the explanation of many other cases, in which pain is inexplicable and persistent. If we could attach more definite meaning to such words as burning, aching, stinging, throbbing, explosive, cutting, and the like, we should often gain more information than we do from our patients' narratives. Many patients will, if only we give them time and show that we are interested in what they tell us, use very expressive epithets in the description of their sensations.